COMMUNICABLE DISEASE CONTROL AMENDMENTS—1972

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

SECOND SESSION

ON

H.R. 14030

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND FOR THREE YEARS THE AUTHORIZATION FOR GRANTS FOR COMMUNICABLE DISEASE CONTROL AND VACCINATION ASSISTANCE

AND

H.R. 14455

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND AND REVISE THE PROGRAM OF ASSISTANCE UNDER THAT ACT FOR THE CONTROL AND PREVENTION OF COMMUNICABLE DISEASES

APRIL 27, 1972

Serial No. 92–66

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COMMUNICABLE DISEASE CONTROL AMENDMENTS—1972

THURSDAY, APRIL 27, 1972

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

We are considering legislation to extend and revise the Vaccination Assistance Act. For the past 5 months we have developed legislation to mount an attack on the Nation's two great killers: cancer and heart. We have passed into law the cancer legislation and have just concluded hearings on heart, lung, and blood legislation. During hearings on both we heard talk of the eventual magic bullet which some day we hope will be given us by the scientific research. In the meantime, we should use available tools of early detection and prevention, for these are about the only magic bullets we have now. We speak of prevention in medicine.

I firmly believe in this concept, and I think the subcommittee does. Certainly this is the approach we need to begin to emphasize more. I think great neglect has been shown in using the tools of prevention in medicine which even now are available to halt the majority of communicable diseases. This is amazing to me. We can prevent measles, rubella, polio, tetanus, diphtheria and yet we really are not doing an adequate job. We have all but eradicated smallpox, but we have not taken the proper action against the other diseases, particularly childhood diseases.

It is amazing that children are still dying from measles here in this country when there really is no reason for this. We fight to restore those who are mentally retarded, often as a result of measles, but fail to act against the diseases which could have prevented it.

There is also the tremendous financial burden that is placed on those people who get these diseases. The measles epidemic in Los Angeles which is just now subsiding will cost people there almost $3 million. Just recently three people died there of measles or measles-related illness. It is estimated 18 to 20 will be retarded and will require lifetime care.

Three years ago we were on the brink of eliminating measles with reported cases down to 22,000 in 1968. But a lack of commitment has allowed this disease to spread to over 75,000 reported cases in 1971.

During the last month figures show over 1,200 cases reported each week or actually about 10,000 children getting measles each week. Statistically, I think we can expect between eight and 10 cases of encephalitis and three children will be mentally retarded and there will be one death each week if we allow this to continue.

It is for many of these reasons that we think great importance should be attached to these hearings and whatever action the subcommittee may take.

(The text of H.R. 14030 and H.R. 14455 and agency report thereon follow:)

92D CONGRESS
2D SESSION

H. R. 14030

IN THE HOUSE OF REPRESENTATIVES

MARCH 22, 1972

Mr. STAGGERS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to extend for three years the authorization for grants for communicable disease control and vaccination assistance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the first sentence of section 317 (a) of the Public Health Service Act (42 U.S.C. 247b (a)) is amended (1) by striking out "and" immediately after "1971,", and (2) by inserting "and $50,000,000 each for the fiscal year ending June 30, 1973, and the next two fiscal years," imediately after "1972,".

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92D CONGRESS
2D SESSION

H. R. 14455

IN THE HOUSE OF REPRESENTATIVES

APRIL 18, 1972

Mr. ROGERS (for himself, Mr. SATTERFIELD, Mr. KYROS, Mr. PREYER of North Carolina, Mr. SYMINGTON, Mr. ROY, Mr. NELSEN, Mr. CARTER, and Mr. HASTINGS) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to extend and revise the program of assistance under that Act for the control and prevention of communicable diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 317 of the Public Health Service Act (42 U.S.C. 347b) is amended to read as follows:

"GRANTS FOR VACCINATION PROGRAMS AND OTHER COMMUNICABLE DISEASE CONTROL PROGRAMS

"SEC. 317. (a) The Secretary may make grants to States and, with the approval of the State health authority, to political subdivisions of States to assist in meeting the

costs of communicable disease control programs. In making a grant under this section the Secretary shall give consideration to the relative extent of the problems, in the area served by the applicant, which relate to one or more of the communicable diseases referred to in subsection (h) (1) and to the level of performance of the applicant in preventing and controlling such diseases.

"(b) (1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Except as provided in paragraph (2), such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(2) An application for a grant for a fiscal year beginning after June 30, 1973, shall—

"(A) set forth with particularity the objectives (and their priorities, as determined in accordance with such regulations as the Secretary may prescribe) of the applicant for each of the programs he proposes to conduct with assistance from a grant under this section;

"(B) contain assurances satisfactory to the Secretary that, in the fiscal year for which a grant under this section is applied for, the applicant will—

"(i) conduct such programs as may be necessary to develop an awareness in those persons in

the area served by the applicant who are most susceptible to the diseases referred to in subsection (h) (1) of the importance of immunization against such diseases, to encourage such persons to seek appropriate immunization, and to facilitate access by such persons to immunization services; and

"(ii) conduct such programs as may be necessary for the detection and treatment of venereal diseases in persons in the area served by the applicant and give priority to the prevention and treatment of venereal diseases in persons who do not have the symptoms of such diseases; and

"(C) provide for the reporting to the Secretary of such information as he may require concerning (i) the problems, in the area served by the applicant, which relate to any communicable disease referred to in subsection (h) (1), and (ii) the communicable disease control programs of the applicant.

"(3) Nothing in this section shall be construed to require any State or any political subdivision of a State to have a communicable disease control program which would require any person, who objects to any treatment provided under such a program, to be treated or to have any child or ward of his treated under such a program.

"(c) (1) Payments under grants under this section may

be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of this section.

"(2) The Secretary, at the request of a recipient of a grant under this section, may reduce such grant by the fair market value of any supplies (including vaccines and other preventive agents) or equipment furnished to such recipient and by the amount of the pay, allowances, travel expenses, and any other costs in connection with the detail of an officer or employee of the Government to the recipient when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such recipient and for the purpose of carrying out the program with respect to which the grant under this section is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based.

"(d) The Secretary shall develop a plan under which personnel, equipment, medical supplies, and other resources of the Service and other agencies under his jurisdiction may be effectively utilized to meet epidemics of, or other health

emergencies involving, any disease referred to in subsection (h) (1). There are authorized to be appropriated to the Secretary $5,000,000 for the fiscal year ending June 30, 1973, $5,000,000 for the fiscal year ending June 30, 1974, and $5,000,000 for the fiscal year ending June 30, 1975, for costs incurred in utilizing such resources in accordance with such plan.

"(e) (1) There are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1973, $50,000,000 for the fiscal year ending June 30, 1974, and $50,000,000 for the fiscal year ending June 30, 1975, for grants for communicable disease control programs relating to venereal diseases.

"(2) There are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1973, $10,000,000 for the fiscal year ending June 30, 1974, and $10,000,000 for the fiscal year ending June 30, 1975, for grants for communicable disease control programs relating to tuberculosis.

"(3) There are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1973, $10,000,000 for the fiscal year ending June 30, 1974, and $10,000,000 for the fiscal year ending June 30, 1975, for grants for communicable disease control programs (other than vaccination programs and other communicable disease

control programs relating to venereal diseases or tuberculosis).

"(4) There are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1973, $5,000,000 for the fiscal year ending June 30, 1974, and $5,000,000 for the fiscal year ending June 30, 1975, for grants for vaccination programs for measles; and there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1973, $10,000,000 for the fiscal year ending June 30, 1974, and $10,000,000 for the fiscal year ending June 30, 1975, for vaccination programs for any other disease referred to in subsection (h) (1).

"(f) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to a political subdivision of a State under other provisions of this Act or other Federal law and which are available for the conduct of communicable disease control programs from being used in connection with programs assisted through grants under this section.

"(g) The Secretary shall submit to the President for submission to the Congress on January 1 of each year a report (1) on the extent of the problems presented by the disease referred to in subsection (h) (1), (2) on the effectiveness of the activities, assisted under grants under this section, in preventing and controlling such diseases, and

(3) setting forth a plan for the coming year for the prevention and control of such diseases.

"(h) For the purposes of this section:

"(1) The term 'communicable disease control program' means a program which is designed and conducted so as to contribute to national protection against tuberculosis, venereal disease, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, whooping cough, or other communicable diseases which are transmitted from State to State, are amenable to reduction, and are determined by the Secretary to be of national significance. Such term includes vaccination programs, laboratory services, and studies to determine the communicable disease control needs of States and political subdivisions of States and the means of best meeting such needs.

"(2) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia."

SEC. 2. The amendment made by the first section of this Act shall apply to grants made under section 317 of the Public Health Service Act after June 30, 1972, except that subsection (d) of such section as amended by the first

section of this Act shall take effect on the date of enactment of this Act.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., May 10, 1972.

HON. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your requests of March 24, 1972 and April 20, 1972, respectively, for the views of this Office on H.R. 14030 and H.R. 14455, bills which would amend the communicable disease control authorities in Section 317 of the Public Health Service Act.

This report will also serve to convey our views on a related bill, H.R. 13219, which you requested on February 22, 1972. This bill deals specifically with the prevention and control of venereal disease.

In testimony before your Committee on April 27, 1972, the Department of Health, Education and Welfare recommended against enactment of these bills. The Department noted that to effectively combat diseases, the patterns of which are constantly changing in time and place, it needs flexible and logically consolidated grant authorities. Narrowly categorical disease control programs established by law create considerable difficulties for State and local communities in carrying out a well-balanced public health program reflecting changing priorities.

The Department further pointed out that sufficient legislative authority already exists in the Public Health Service Act to carry out the programs authorized under the bills cited above.

The Department recommended that in lieu of these bills the Committee act favorably on H.R. 14341, which would provide for an increase in the authorization ceilings in the flexible Partnership for Health authorities of section 314(e) of the Public Health Service Act from $157 million to $179 million for fiscal year 1973.

We concur in the views expressed by the Department of Health, Education, and Welfare and, accordingly, recommend enactment of H.R. 14341 rather than the categorical authorities provided in H.R. 14030, H.R. 14455, and H.R. 13219. Enactment of H.R. 14341 would be in accord with the program of the President.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

Mr. ROGERS. We have as our first witness today the distinguished Member of Congress who is vitally interested in health matters, and has indicated it by his actions. We are pleased to welcome to the committee our colleague, the Honorable Edward I. Koch, Member of Congress from New York.

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. KOCH. Thank you, Mr. Chairman and Mr. Nelson. I am very pleased and privileged to appear before you this morning in support of your bill, Mr. Chairman. The reason that I asked to come before the committee is not to furnish you with additional information because it is obvious that this committee has the information and nothing that I could bring to bear would increase that store, but the purpose of my appearance before the committee is to indicate the fact that not enough attention by the public is being given to this problem, and I thought by coming before your committee I might focus some more attention on the matter.

I personally visited one of the TB clinics in the city of New York, located in the Harlem Hospital, not very long ago. I did it frankly with the thought that I could bring up some newspaper reporters and some television people to see the problem, because there is a blackout, so to speak, not of a conspiratorial kind with respect to this illness, but

everybody thinks it has been conquered, it is over, it has disappeared and therefore why is anybody talking about tuberculosis in 1972.

The fact is, as you gentlemen know better than anyone else, it has not disappeared. The fact of the matter is that it is escalating. The reason that it is escalating is that the moneys that could be applied to eradicate it simply have not been furnished.

As you know, the moneys which this great committee authorized in the last authorization bill was in the amount of $90 million, $20 million was actually appropriated for all of the communicable diseases under that section and not a single dollar in fact went for the control and eradication of TB. Therefore, the bill which I come before you to support, your bill, Mr. Chairman, which would earmark funds for TB, is crucial.

I should like to make this observation, too. It seems to me, and I do not pretend to have any expertise, that what we are dealing with is a disease which has as its greatest victims the people who can do least for themselves because of poverty. We are talking now about the blacks, the Puerto Ricans, and the chicanos who are the people who have gotten least out of our economy and, therefore, are able to afford the least amount of medical assistance and are the ones whose diet is not the best, and therefore, we have an extra obligation to come in and provide the means to eradicate at least this particular disease which does not require research and development. We know the answers, the answers are simple: The answers are medication and prevention and it is simply a question of money.

I have attached to my full formal statement—and I would ask permission to submit the full formal statement with the exhibit for the record.

Mr. ROGERS. Yes, without objection it will be made a part of the record.

Mr. KOCH. Thank you. A list of the cities of over 500,000 with newly reported cases of tuberculosis accompanies the formal testimony.

As you, again, know so well, the national rate of incidence of tuberculosis is 18 cases per hundred thousand. It seems to me that the Members of Congress should be outraged that here in the District of Columbia where we in fact sit, the national rate is 48.9 per hundred thousand, that in the city of Baltimore, which is a stone's throw away, the rate is 54.4. In my own city of New York the rate is near twice the national rate of 32.8; that is, our rate is 32.8. What is also appalling is that in the city of New York the rate in central Harlem, which is our major ghetto where the black population lives, is 139.9 as opposed to the national average of 18.

On the lower East Side where we have a large ghetto of Puerto Rican population the rate is 90.2. Therefore, the facts are there, the problem that we run into on a congressional level, and you know the problem better than I because you have been here so much longer than I, but I see it all the time, we always have the complaint from the Appropriations Committee that the authorization bill has come in late, then when they have the appropriation bill it will generally be for a much smaller sum than is authorized with the thought that "if you need the money come in later and we will provide it." When the supplemental bill comes up they say it is so close to the end of the

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year "you cannot possibly spend it." It is a vicious circle and the victims are the impoverished and they are the ones who need our help.

I want to commend you once again for the marvelous work that this committee is doing and I hope you have success.

(Mr. Koch's prepared statement follows:)

STATEMENT OF HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman and Members of the Committee. I appreciate having the opportunity to appear before you today. I would like to address myself to the anticipated loss of federal funding for tuberculosis programs throughout the country under Section 317 of the Public Health Service Act for the Communicable Disease Control Program and the accompanying danger that the nation may suffer a sharp increase in active tuberculosis cases if the federal government does not support immunization and treatment programs.

I fully support Chairman Rogers' bill, H.R. 14455, which provides $10 million a year for fiscal years 73, 74, and 75 for tuberculosis programs.

I understand that the programs financed under Section 317 are now still using $2 million in funds released late in fiscal year 1971. There was no money appropriated for tuberculosis programs under this section in fiscal year 1972. Although $20 million was appropriated for fiscal year 1972 under the Communicable Disease Control Program, $16 million was earmarked for venereal disease programs and $4 million for other immunization programs not including tuberculosis. The Congress had authorized $75 million for fiscal year 1971 and $90 million for fiscal year 1972.

Tuberculosis is the only disease among the 20 main causes of death in the United States in which all the research has been done; we know how to cure it. Those areas in which the incidence of tuberculosis is high reflect the economic and social problems of the community which cause disease to increase in poverty areas. The delivery of health care to these areas must be supported and improved, not curtailed.

In 1970, tuberculosis killed 5,560 Americans and newly affected 37,137. Of these 386 deaths and 2,590 new active cases were in New York City. The national rate of incidences of tuberculosis is 18 cases per 100,000 persons. In 1970 the New York City rate was 32.8; the rate in Central Harlem was 135.9; on the Lower East Side 90.2; and in Bedford Stuyvesant 74.9. In addition, 1.5 million persons are estimated to be infected with the tubercle bacillus and each is at a variable rate of developing active tuberculosis, some needing chemotherapy. If the programs treating these persons are not supported, and if tuberculosis surveillance is curtailed because of lack of funds, we all take the risk of having a rise in tuberculosis cases in our communities. I am appending to this testimony a list of those cities with populations of over 500,000 persons with newly reported cases of tuberculosis.

Joseph T. English, M.D., former Administrator of the Health Services and Mental Health Administration of HEW recently spoke before the Tuberculosis and Respiratory Disease Association of NY of the need for this financing for tuberculosis programs. I quote from his testimony:

"Two years ago when I had the opportunity to address the National TB Association, I urged you to redirect your support to the comprehensive approach to health services planning and delivery and specifically I urged your support of the newly developing Comprehensive Planning Agencies. Now, two years later and faced with current problems my recommendation to you must change. It is clear to me that too much of the support which the present administration is providing to comprehensive health efforts is being done at the expense of still necessary categorical programs—programs which have proven themselves to be dramatically effective over the years. This is nothing but a shameful shell game. Continued support of proven programs together with comprehensive health efforts must be guaranteed. New money is absolutely essential, and any effort to obscure this fact, any effort to sacrifice one critically valuable program to develop another is both deceitful and damaging to our citizens."

Funds for venereal disease were cut in the mid-sixties when the incidence of VD was decreasing. From a public health point of view, this cut in funds was disastrous because the disease burst out again and is now almost of epidemic proportions. We cannot let the same thing happen with tuberculosis.

The following is a list of those cities with populations of over 500,000 persons with newly reported cases of tuberculosis. The national rate of incidences of tuberculosis is 18 cases per 100,000 persons.

	Rate per 100,000
Baltimore	54.4
District of Columbia	48.9
Boston	48.0
Detroit	47.6
Cincinnati	47.3
San Francisco	45.7
Chicago	45.6
Cleveland	41.3
Pittsburgh	39.0
Philadelphia	38.9
Atlanta	38.3
Buffalo	35.7
San Antonio	35.6
Houston	35.5
New Orleans	33.0
New York	32.8
Dallas	29.4
Miami	28.2
Los Angeles	28.2
St. Louis	28.1
Kansas City	28.0
Seattle	27.5
Phoenix	19.4
Columbus, Ohio	18.2
San Diego	16.1
Denver	14.8
Minneapolis	13.8
Milwaukee	12.3

Mr. ROGERS. Thank you very much. The committee appreciates your great interest in this subject and your support on the floor.

Mr. KOCH. Thank you so much.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. I have no questions. I want to thank my colleague for his statement. The thought occurred to me that in the State of Minnesota many years ago we embarked on a program of testing our livestock and we finally totally eliminated the problem of TB in our dairy cattle. Maybe we have done a better job with our dairy cows in Minnesota than we have done in some cases with some of our population.

I want to thank the gentleman.

Mr. KOCH. Thank you so much.

Mr. ROGERS. The next witness will represent the Department of Health, Education, and Welfare. We are pleased to welcome Dr. John Zapp, Deputy Assistant Secreary for Legislation (Health).

I understand you will be accompanied by Dr. David Sencer of the Center for Disease Control, Health Services and Mental Health Administration, HEW, and Edgar N. Duncan, Acting Deputy Administrator for Health Services Delivery, HSMHA, HEW.

Do you have any others that you desire to bring to the table?

STATEMENT OF DR. JOHN S. ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL, HSMHA; AND EDGAR N. DUNCAN, ACTING DEPUTY ADMINISTRATOR FOR HEALTH SERVICES DELIVERY, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Dr. ZAPP. No, I think this will be adequate, Mr. Chairman.

Mr. Chairman, members of the Subcommittee on Health, it is a pleasure to be here today as the Department of Health, Education, and Welfare witness on a subject of great concern to both of us, the prevention and control of communicable diseases. We share with you a great optimism for the potential of preventive medicine in reversing risky and expensive crisis intervention mode of practice to a more dependable health surveillance and maintenance approach. Nowhere is this more evident than in our combined attention to the control of communicable diseases.

CURRENT POSSIBILITIES

In fact, new-developed vaccines, drugs, and improved methodologies make it possible to project realistically not just the cure but the eradication of many historically communicable disease "plagues". Just within the past year we have seen our strategy for the control of smallpox, one of the most dreaded infectious diseases, reach full cycle. Our concern had been to keep immunization levels high and to maintain vigilance at our borders to assure against importation of the disease from countries where it was still endemic. As a result of the World Health Organization's wordwide smallpox eradication program of which the Department of State and the Department of Health, Education, and Welfare were active participants, the global situation has changed dramatically. Worldwide eradication is now being realistically predicted; therefore, the threat of importation has been dramatically reduced. As a result, we are now able to recommend the discontinuance of routine smallpox vaccination for the Nation as a whole.

DEPARTMENT GOALS AND PREMISES

Disease patterns are constantly changing in time and place. To effectively combat these diseases, we must have flexible and logically consolidated grant authorities. Our preference for flexible and logically consolidated grant authorities for these kinds of situations has been often stated in the past. We opposed the Communicable Disease Amendments of 1970 on this basis and remain opposed to the establishment of narrow categorical grant programs.

PENDING BILLS

H.R. 14455, introduced by you and other members of the subcommittee, would amend section 317 of the Public Health Service Act by providing six different categorical appropriations ceilings for the 3 fiscal years, 1973 through 1975. The first of these authorizations is $5

million for direct operations to meet epidemics, and the other five are for project grant programs to State and local health departments for specific communicable disease control programs as follows:

For venereal disease, $50 million.

For tuberculosis, $10 million.

For other communicable disease not specifically covered in this bill, $10 million.

For measles, $5 million.

For rubella, poliomyelitis, Rh disease, diphtheria, tetanus, and whooping cough, $10 million.

The establishment of such a large number of narrowly categorical programs by legislation would create considerable hardship in State and local communities in carrying out a well-balanced public health program based upon the changing priorities and needs of the State or local communities. Sufficient legislative authority already exists in the Public Health Service Act particularly in sections 301 (Research and Investigation), 311 (Federal-State Cooperation), and 314 (Partnership for Health) to carry out all the programs authorized under this bill.

The committee is also considering H.R. 14030, introduced by Congressman Staggers, "Communicable Disease Control Amendments"—which would amend section 317(a) by authorizing $50 million for fiscal year ending June 30, 1973, and for each of the next 2 fiscal years for communicable disease activities.

In addition, the committee is considering two similar bills, H.R. 13219, introduced by Congressman Hastings, and H.R. 13365, both entitled "The National Venereal Disease Prevention and Control Act."

H.R. 13219 would add section 318 to the Public Health Service Act and authorize the Secretary to conduct and render assistance to appropriate public authorities and scientific institutions in the conduct of research, training, and public health programs relating to the prevention and control of venereal disease.

The proposed legislation is for a 3-year period, fiscal years 1972–1974, with a total appropriation authorization of $70 million each year. Of this total, $15 million is authorized for project grants to public or nonprofit organizations to carry out research, demonstrations, or training for the prevention or control of venereal disease; $25 million is authorized for formula grants to States for venereal disease diagnostic and treatment services; and $30 million is authorized for project grants to States for carrying out venereal disease prevention and control programs.

The bill also amends section 314(d)(2) of the Public Health Service Act to require that in order to be approved, a State plan for provision of public health services must, effective July 1, 1973, provide for services for the prevention and control of venereal disease.

While all of these bills are aimed at solving serious public health problems, we believe that our present grant authorities are adequate to cover all of the purposes for which grants would be authorized under the proposed legislation. Under section 301, venereal disease research can and is being supported through the National Institutes of Health; and prevention and control activities are being supported under section 314 of the Public Health Service Act. Under section 314(d) of this act, block type formula grants are available to States

to support a variety of public health programs including venereal disease. Venereal disease project grants have been funded from section 314(e) of this legislation since its enactment.

Present authorities, as cited, I think offer ample support for ongoing activities in these areas in which we are all vitally interested. The record of what has been achieved in response to the Nation's most urgent communicable disease prevention and control needs can, I think, be best illustrated by reviewing, in a number of critical areas, the changes in disease incidence reported to the Center for Disease Control by State health departments.

POLIO

In 1962, when the Vaccination Assistance Act was passed, the original section 317 of the Public Health Service Act, we found that poliomyelitis had once again become "infantile paralysis." After the early successes with the Salk vaccine, a new reservoir of unprotected children was built up as large numbers of the newborn added each year to the population went unvaccinated. At that time, too, a new oral polio vaccine was being developed which would permit not only simpler, less painful administration but also more effective, longer lasting protection. The Vaccination Assistance Act was designed to take advantage of this development and at the same time to ride the coattails of the new vaccine and to attempt to raise the levels of protection against diphtheria, whooping cough, and tetanus. The following is a comparison of the number of cases of polio at the beginning and end of the decade.

In 1962 there were 910 cases of paralytic polio.

In 1972 there were 12 cases of paralytic polio.

Looking back over the 10-year period, we find that we have a better immunized population and that protection has resulted in a dramatic drop in the number of cases of paralytic polio. Admittedly, the situation is not as simple as the figures would imply. For in the past few years, immunization levels have slipped off, creating concern that localized outbreaks might occur. When it was found that there were pockets of nonimmunized children, it was possible to respond rapidly to this need by reprograming funds under section 314(e) that had become available because of reductions in the price of rubella vaccines. This was accomplished under the authority of section 314(e) without any legislative revisions.

MEASLES

In 1963 a measles vaccine became available; however, it did not enjoy widespread use. Acceptance of the vaccine was hampered by its high cost and by the fact that the public had learned to accept measles as a mild childhood disease that was simply a part of growing up. As a nation, we were not fully aware of the drastic side effects that could accompany the disease—death, disability, and mental retardation.

To correct the situation, the Vaccination Assistance Act was extended and amended to include the support of a measles vaccination program. This was the Community Health Service Extension Amendment of 1965. Under this authority, a nationwide measles control program was undertaken. The success that was achieved in a few short years under that program is reflected in a comparison of reported measles cases in 1962 and 1971 (it should be kept in mind that 10 years ago measles was grossly underreported).

In 1962 the number of reported cases of measles was 481,530.

In 1972 the number of reported cases of measles was 75,000.

Since measles is a very highly infectious communicable disease, a slight falloff in immunization levels unfortunately resulted in a sharp rise in the number of cases of measles, which is not reflected in the above data. As was the case with polio, the administration met this problem by directing funds available under section 314(e).

RUBELLA

Rubella, or German measles, was another childhood disease which we had no means of preventing and whose apparent mildness masked serious, heartbreaking consequences, not to the person with the disease, but rather to unborn children. Pregnant women who contracted rubella during the first trimester of their pregnancy ran the terrible risk of having a child born with severe congenital malformations or mental retardation. In the fall of 1968, when it became apparent that there was a good chance that a rubella vaccine would be licensed for use in the United States, the Department began work on the development of a rubella control program. As a result of this program planning, a supplemental appropriation request for fiscal year 1969 had been submitted to Congress before the new vaccines had been licensed. Funds for this activity were requested and provided under the broad authority of section 314(e). The administration and Congress responded so quickly to this opportunity that programs were underway in the summer of 1969. This rapid mobilization of Federal, State, and local resources had, at first, strained the production capabilities of the health industry—a temporary situation which was quickly resolved. Since the rubella vaccine was licensed only in May 1969—a period of time which can be counted in terms of months—more than 31 million children have been immunized against rubella.

Having reached about 70 percent of the prepubertal school children, we are now concentrating on immunizing preschoolers. This is an achievement of which we can be very proud. And, I am convinced that when the program is completed, we will have witnessed one of the Nation's biggest successes in modern day preventive health—and it will have been done without special legislation.

TUBERCULOSIS

It was in fiscal year 1962, under point of order authority contained in the appropriation act, that special project grants for tuberculosis control were first authorized. This also marked the beginning of the Department's effort to modernize tuberculosis control activities across the Nation. More specifically, the Department was striving to: (1) achieve more widespread use of the drug isoniazid for both treatment and prevention of tuberculosis, (2) change the concept of tuberculosis care from one of long-term hospitalization to an approach that combined a shorter hospital stay with outpatient treatment, and (3) generally improve the management of tuberculosis cases.

In 1962 the number of reported cases of tuberculosis was 53,315. In 1970, the number of reported cases of tuberculosis was 37,137.

The results of the program are, however, more significant than the number of cases indicated. As a result of the prevention of new cases

and the reduction in the length of hospital stay and other such factors, it has been estimated that the program had resulted in the savings of nearly $500 million to the American people. And, the actual rate of decline of new active cases has been greatly accelerated during the decade.

VENEREAL DISEASE

Syphilis—During fiscal year 1961, a special task force was brought together to study the problem of syphilis control. The incidence of syphilis had reached an alltime low in 1957 but by 1960 it was clearly on the upswing again even though effective treatment was available. The task force recommended a syphilis eradication program which served as the basic strategy for the Department's syphilis eradication effort during most of the decade. Thus, with syphilis we are dealing with a disease for which we have had available effective techniques and program methods. These have been applied during the past 10 years with the result that the incidence of syphilis has generally been held in check compared to gonorrhea which has continued to spiral upwards. Additionally, there were better reporting methods for syphilis which provide us with a more accurate picture of the incidence. The program has been successful in achieving a coordinated nationwide attack on syphilis which has included updated programs for case reporting, followup, and treatment to both cure and prevent disease.

It has also included the development of surveillance on the State, local, national, and even international basis to better assure that infectious individuals or suspect cases are brought to treatment. During the decade that number of new infectious cases was reduced and syphilis was on the downswing. In the last few years, however, it is unfortunate that there has been an increase in the number of reported cases of primary and secondary syphilis.

In 1962 the reported cases of primary and secondary syphilis was 30,084; in 1969 the number of reported cases was 18,679, and in 1971 the number of reported cases was 23,226. This administration's new venereal disease initiatives are designed to reestablish the downward trend in syphilis incidence. Like the tuberculosis control program, this nationwide eradication campaign was carried out under point-of-order authority until the passage of comprehensive health legislation in 1966.

Gonorrhea—With gonorrhea we have been faced with an entirely different set of problems. Until recently we have not had available to us the basic scientific ingredients of an effective public health program for controlling the disease. And, the history of the disease reflects this gap in our knowledge. Reported gonorrhea has increased in all but one of the past 17 year. During this decade the disease trend looked like this:

In 1962 the number of reported cases of gonorrhea was 260,468. The number of reported cases in 1971 was 624,371. It should be pointed out, however, that these figures show only a small part of the total disease problem. Studies have shown that the disease is greatly underreported and that actual incidence may be about 2.5 million cases annually.

In late 1971, the Center for Disease Control reported success on two fronts. First, special pilot programs that were conducted in the field indicated that if effective diagnostic techniques were available, public health control programs would be operationally feasible. Second, in

the laboratory, an effective diagnostic technique was developed and tested which now makes it possible to overcome a major obstacle to the control of gonorrhea—the inability to detect the disease in infectious, but asymptomatic females. It was now possible to recommend for the first time that effective public health programs for the control of gonorrhea could be undertaken. To strengthen the national VD program, the President's budget includes a total of $31 million for fiscal year 1973 of which $24.8 million is for project grant funds. These funds will reestablish the downward trend in syphilis and start to bring gonorrhea under control. To carry out this initiative, ample statutory authority already exists and all that is required is an increase in the appropriation ceiling in section 314(e).

For these reasons, we have requested that the Congress raise the authorization ceiling for section 314(e) from $157 million to $179 million, under which we propose to carry out these activities. Legislation which would provide this increased authorization has been introduced as H.R. 14341 by Chairman Staggers and Congressman Springer. Favorable action on this bill would preserve these broad, flexible authorities and increase our ability to respond to high priority national health needs.

SUMMARY

This review of the past 10 years substantiates our position that comprehensive, flexible, legislative authority is most appropriate for dealing with either emerging national health problems or emerging opportunities resulting from technological developments. The experiences we have had with the polio and measles opportunities illustrate the desirability of conducting programs under the flexible partnership for health authorities. Development of the Vaccination Assistance Act started in December 1961, resulted in legislation in October of 1962, but was not funded until the enactment of a supplemental appropriation in May 1963. Similarly, although the measles vaccine was licensed in March 1963 and program development was begun in September 1964, funds were not made available until October 1965. This contrasts sharply with the Government's ability to take advantage of the new rubella vaccine under the partnership for health provisions. When it became evident that the licensure of the rubella vaccine was imminent, a supplemental budget request was sent to Congress.

I am sure the committee will agree that this is the kind of responsiveness to health needs and opportunities that is necessary for the Department to have a national health protection. It is the kind of responsiveness that is possible under a broad authority such as that of section 314(e) and for this reason we recommend against extension of section 317.

Accordingly, we recommend against enactment of the bills under consideration to continue categorical statutory authority for communicable disease programs. Instead, we strongly recommend that you further improve the comprehensive health partnership legislation by increasing the authorization ceilings in section 314(e) of the Public Health Service Act for fiscal year 1973 from $157 to $179 million, as proposed in H.R. 14341, which would permit us to take advantage of improvement opportunities as they arise.

Mr. Chairman, my colleagues and I would be pleased to answer any questions you and other members of the subcommittee may have.

I might say that Mr. Duncan, who is here with me, is an expert on the partnership for health programs and Dr. Sencer, director for CDC, is an expert on programs in the past.

Mr. ROGERS. Thank you so much. We appreciate your statement.

Mr. Nelsen?

Mr. NELSEN. I do not know that I have questions at the moment. I will reserve my opportunity for interrogation until later.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

What do you recommend, Dr. Zapp, as an appropriation for the detection, prevention, and treatment of tuberculosis?

Dr. ZAPP. The tuberculosis programs, Dr. Carter, we have moved from 314(e) into the 314(d) which are the block grants to the States. The block grant is for the States to use on the disease problems that are most prevalent within their States.

Mr. CARTER. What is your total recommendation?

Dr. ZAPP. The total 314(d) allocation is $90 million.

Mr. CARTER. Is that less than it has been in the past?

Dr. ZAPP. No, the 314(d) is the same as it was last year, as I recall.

Mr. CARTER. How is the rate of incidence of tuberculosis in 1965 compared with that at the present time?

Dr. ZAPP. I will refer that question to Dr. Sencer.

Dr. SENCER. If my memory serves me correctly, Dr. Carter, in 1969 tuberculosis was declining at a rate of about 9 percent per year. In the past year the decline was about 5 percent.

Mr. CARTER. The rate of decline has diminished?

Dr. SENCER. That is right.

Mr. CARTER. We might expect that. This is one area in which public health and the medical profession has done extremely well, has done great work. I can remember quite well when this was really a widespread disease, much more widespread than it is today. I think we should continue our surveillance, our testing. Do you recommend routine tuberculosis tests throughout our country or not?

Dr. SENCER. At the present time we do not recommend routine testing for our entire population. We think we have to limit our testing to those populations that we know would be at high risk. We believe that people who are living in our inner cities, who are seeking medical services for other reasons, are more likely to have tuberculosis than healthy adults at work. So our X-ray screening is almost entirely done in hospitals and outpatient clinics at the present time.

Mr. CARTER. I notice you recommended widespread use of INH.

Dr. SENCER. The recommendation for use of INH is for people who have evidence of being newly infected but as yet do not have the disease, household contact of patients with tuberculosis, and people who have X-ray abnormalities but no active tuberculosis.

Mr. CARTER. Has there been an over use of INH?

Dr. SENCER. I personally don't think there has been an overuse of isoniazid in this country. I think many areas of the country have been reluctant to use it in people who are high risk. I think I understand your line of questioning, Dr. Carter, considering the appearance of some cases of heptatis not only on Capitol Hill but in other parts of the country. We had an expert committee get together to

review our recommendations. The committee included people from outside Government and people with the National Tuberculosis and Respiratory Disease Association. On the advice of the committee we continue to recommend isoniazid on a prophylactic basis for the groups I mentioned before. In addition, we urge that all people who are receiving isoniazid be under routine medical supervision.

Mr. CARTER. I think that it is quite necessary to be under supervision. Haven't we had some deaths on the Hill from the use of INH?

Dr. SENCER. There were two people from the Hill who died. There is litigation about these two cases at the present time. So I would just as soon not say whether it was cause or effect.

Mr. CARTER. They were taking INH?

Dr. SENCER. Yes, sir.

Mr. CARTER. I personally from my experience feel it has been extremely helpful in most cases, but it is a rather dangerous drug. The real isonicotinic acid hydrazide—I refreshed my memory on that just a minute ago. There has been an upswing in the incidence of the neisserian infection; has there not?

Dr. SENCER. Very definitely yes.

Mr. CARTER. How do you account for this?

Dr. SENCER. I think that there are many reasons that can account for the upswing in gonorrhea infection. One I think has been, and still is a generally held idea that it is a minor disease, it does not cause a great deal of problems. It can be easily treated. We know in males it is not a minor disease initially and most males seek treatment. However, we have come to recognize in the past several years that there is a large number of women with the disease who have no symptoms but who are capable of transmitting it to other people. There have been suggestions that there have been changes in our society that have led to greater promiscuity.

We have very little firm evidence of this. I think there is only anecdotal material supporting that idea. There is also a belief that the present methods of contraception, basically the pill and the interuterine device, offer no mechanical barrier. All previous types of contraception had some form of mechanical barrier. It is the belief in some circles that this change in practice may have some part to play in this increase in gonorrhea.

Mr. CARTER. In other words, using the pill instead of mechanical means of prophylaxis may have caused this increase?

Dr. SENCER. Yes, sir.

Mr. CARTER. Has the use of the pill increased promiscuity, do you think?

Dr. SENCER. There really is no firm basis on which to make that statement.

Mr. CARTER. It would be rather difficult to really get that information, wouldn't it? But there is definitely an increase, I think there is no question about that.

Dr. SENCER. Sir, there may be another reason for the increase. That has been inadequate treatment in many of the cases. It is not that the organisms are resistant to penicillin but there is a wide variety of treatment regimens in use. Many are inadequate to treat individuals. We recently conducted a survey in one of our States of 150 cases of

gonorrhea, I think there had been 43 different regimens used to treat the cases. Most of them were inadequate to bring about a cure.

Mr. CARTER. Do you think penicillin is the drug of choice?

Dr. SENCER. Yes, sir.

Mr. CARTER. Does it cure every case?

Dr. SENCER. If an individual is not sensitive to penicillin and if penicillin is given in adequate amounts, it is a curative drug.

Mr. CARTER. It is a curative drug but not in every case. The organisms can become penicillin resistant. In many, many cases this happens.

You still have a Gram-negative smear in some cases. It is rather difficult. What are the bad effects of gonorrhea?

Dr. SENCER. Gonorrhea in the male, if untreated, can lead to urethral stricture and to chronic renal disease. In the females the most common complication is inflammatory disease of the fallopian tubes, pelvic inflammatory disease, which can lead to sterility or extremely serious infection that results in major surgery that again will lead to sterilization.

Mr. CARTER. It causes sterility in the male, too, does it not?

Dr. SENCER. It can get into the seminal vesicles, yes, sir. I think there is a fair amount of gonorrheal arthritis seen in people who have the disease.

Mr. CARTER. Not as much as formerly, though?

Dr. SENCER. We have been observing the complications of gonorrhea in several communities in the past year. When you begin to look for it there is an increase in gonococcal arthritis at the present time.

Mr. CARTER. I hate to hear that.

Dr. SENCER. It corresponds with the increase in the disease.

Mr. CARTER. Do you have any blindness of the newborn any more?

Dr. SENCER. No, sir. Just about every State has some type of legislation that insists upon care of the eyes. This is not a major problem.

Mr. CARTER. That is good. That was one of the best laws that the States have ever passed.

Syphilis has been a very interesting disease over the years. It mimics almost every other disease you can think of, is that not true?

Dr. SENCER. Yes, sir.

Mr. CARTER. We have seen an increase in the number of these cases over the past few years.

Dr. SENCER. In the past 2 years there has been an increase in the amount of infectious syphilis. The total number of cases of syphilis is going down—people who are being discovered in the latent and tertiary stages—is going down. The increase we have seen is in the infectious stages, the early stage.

Mr. CARTER. There has been a dramatic decrease in that over the years. As a young medical student I saw a great amount, huge amount, of this, a disgusting but at the same time very interesting, very interesting disease. It causes all sorts of symptoms. Have you seen many chancres lately?

Dr. SENCER. I personally spend most of my time at the desk. There are about 20,000 cases reported of infectious syphilis each year.

Mr. CARTER. Do you see these chancres in any unusual locations?

Dr. SENCER. There continue to be reports of chancres in various parts of the body—anal chancres, oral chancres.

Mr. CARTER. On the lips.

Dr. SENCER. Yes, sir.

Mr. CARTER. Could you give us some of the symptoms of the secondary stage? Of course, the chancre is the first stage.

Dr. SENCER. The secondary stage is again one of the great imitators. You have a wide variety of skin lesions that can be seen. Sore throat is a very frequent complication from mucosal irritation. We wish some of our ear, nose, and throat brethren would do a better job of drawing blood when they see an unusual throat lesion. But skin, throat, and mucous lesions are the prominent things you see.

Mr. CARTER. Mucous patches, they are called?

Dr. SENCER. Yes, sir.

Mr. CARTER. Once you see them, see them a few times, you can recognize them quite readily.

Dr. SENCER. One of the problems that Dr. Webster will probably bring out later is the fact that not many of our medical students are seeing these things today. Most syphilis is being treated on an outpatient basis where they are not being used for teaching purposes. We have many people graduating from medical school today who have never seen primary or secondary lesions.

Mr. CARTER. Have you ever seen condylomata lata?

Dr. SENCER. I have heard of it.

Mr. CARTER. You have never seen it?

Dr. SENCER. I have seen it back in the early 1950's, late 1940's.

Mr. CARTER. It has been rather widespread in years past.

Dr. SENCER. Yes.

Mr. CARTER. Of course, that is the part that becomes immediately noticeable after the second, or part of the second, stage. There are different skin lesions which occur with that.

Sometimes even then you notice cerebral symptoms which occur with fever along with mucous patches. You observe the cerebral symptoms that they have, the psychoses that they have often as early as this. Is this not true?

Dr. SENCER. Yes. I think, though, the psychoses and central nervous system symptoms are more likely to appear together.

Mr. CARTER. That comes many years later, but you do see it with the secondary invasion. The man who thought he has been treated adequately may find it turns up years later in a form in which our friends in medical school used to recite.

"There was a young man from Cathay
Who thought syphilis just went away:
Now he has tabes and saber shin babies.
And thinks he's the Queen of the May."

That is, the man who is inadequately treated, 20 years after that he developed this trouble. We are not seeing so much of the third stage?

Dr. SENCER. No, sir. Thankfully, most syphilis is being recognized in the primary and secondary period where it can be treated.

Mr. CARTER. And adequately treated. We have much better means of treating it today than we had at one time. Occasionally we do see paralysis, stroke, from the third stage of syphilis. Is that not correct?

Dr. SENCER. There are still a small number of people who are having paralytic disease and a few who are admitted to our mental institutions but it is fortunately declining, very, very rapidly.

Mr. CARTER. When these strokes are caused by gummatous lesion, treatment sometimes will take care of the lesions and the paralysis in some cases. I have seen that. This is a dread disease, although, as I said, a very interesting one. I think we should continue our efforts toward its eradication. Are you asking for the same authorization, or more?

Dr. ZAPP. We are asking for additional sums in the venereal disease initiative this year. Our dialog with the committee is simply the method by which we would disburse it from the Department. We agree with the committee that increased sums are necessary.

Mr. CARTER. In many cases we have unfortunate wives who have a neisserian infection—we will put it politely. Do you have any means of detection rather than a vaginal smear?

Dr. SENCER. At the present time the vaginal survival smears are the only method of detecting gonorrhea in the female. There is research going on at the present time looking for a serologic test for gonorrhea so that it could be done through a blood test. I do not hold out hopes this will be available in the next year or 2 years. I think there are even more exciting things going on in terms of some of the newer technologies in chromatography to see if it is possible to use this method to diagnose gonorrhea from urine.

Mr. CARTER. I might object but I think when a Pap smear is done I think perhaps it would be wise to——

Dr. SENCER. As part of our new initiative in gonorrhea this year we are encouraging that at any time that a woman is being examined between the ages of 15 and 40 or 45, whether it is for prenatal examination or postnatal examination, family planning services, or Papanicolaou that it be appropriate at the same time to take a smear for culturing for gonorrhea. There are new media available at the present time that makes this widespread screening much more feasible than it was in the past.

Mr. CARTER. I think perhaps some of my committee members might now have a better understanding of what these diseases do to people.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you, Dr. Carter, for bringing these points out.

Mr. Preyer?

Mr. PREYER. I have no questions at this time, Mr. Chairman.

Mr. ROGERS. What is the budget of the CDC?

Dr. SENCER. Our total budget is $95 million.

Mr. ROGERS. How many personnel do you have?

Dr. SENCER. Around 2,460.

Mr. ROGERS. Are these scattered over the country?

Dr. SENCER. Yes, sir. Only about half of our personnel are in Atlanta; the other half are assigned either to State local health departments or stations.

Mr. ROGERS. Do you have an increase in personnel, or a decrease?

Dr. SENCER. Our personnel in next year's budget shows an increase of 75 positions.

Mr. ROGERS. Have you had a decrease in the years before that?

Dr. SENCER. Yes, there has been a slight but steady decrease.

Mr. ROGERS. I think it would be well to set that out in the record for us, and your funding.

Dr. SENCER. Yes, sir.

(The following information was received for the record:)

CENTER FOR DISEASE CONTROL, POSITIONS AND APPROPRIATED FUNDS ADJUSTED TO INCLUDE GRANTS

	Permanent positions	Amount
Fiscal year:		
1963	1,547	$33,940,000
1964	2,587	53,554,000
1965	2,236	51,011,000
1966	2,365	74,555,000
1967	2,451	76,410,000
1968	3,280	96,643,000
1969	3,226	88,430,000
1970	2,359	[1] 57,868,000
1971	2,332	69,538,000
1972	2,386	[2] 90,343,000
1973 estimate	2,461	95,279,000

[1] Pesticides and aedes aegypti programs transferred out of CDC.
[2] Net of employment reductions and organizational transfer of nutrition and smoking and health programs into CDC.

Mr. ROGERS. Now these funds come from what source?

Dr. SENCER. In the fiscal 1973 budget all of the funds will come from our own appropriation. In previous years grant funds used for communicable disease control were shown in the appropriation for comprehensive health services. This year they all show in our own budget under disease control.

Mr. ROGERS. Do you allocate the funds or are they done on a State by State basis?

Dr. SENCER. The actual allocation is made by our regional offices, the 10 regional offices of HEW. We establish guidelines as to how funds can appropriately be used and provide this to the regional offices. The States then make a grant application, spelling out what they are going to do with the money, and if it meets the guidelines and sufficient funds are available the grant is awarded by the regional office.

Mr. ROGERS. In other words, you are saying an area before they got money would have to say I am going to spend so much for a certain disease?

Dr. SENCER. Yes, sir. These are what we refer to as project grants rather than block grants.

Mr. ROGERS. It would be categorical, then.

Dr. SENCER. Yes.

Mr. ROGERS. Not just a block grant to the State.

Dr. SENCER. No, sir.

Mr. ROGERS. So you really are encouraging categorical approaches here.

Dr. SENCER. The actual approach to disease control has been on a categorical basis. By this being in the 314(e) appropriation it can move from one area to another without being limited to a specific category.

Mr. ROGERS. But you are requiring them to categorize in their request to you.

Dr. ZAPP. Yes, much the same, Mr. Chairman, as we would with any other project grant that would differ from the block grant. The State that uses it would have to be identified, the difference being that it would not have to be a national program. It could be because of a

regional problem or if the emphasis were changed the next year that the project grants could be completely turned around to another disease in another part of the country.

Mr. ROGERS. Then you are not speaking of partnership for health funds?

Dr. ZAPP. Yes, under 314(e).

Mr. ROGERS. Are you giving block grants to the States and letting them make a determination——

Dr. ZAPP. Both.

Mr. ROGERS. What percentage?

Dr. ZAPP. The 314(d), which is a block grant, there are $90 million in the request.

Mr. ROGERS. That is not just for communicable disease?

Dr. ZAPP. No, sir.

Mr. ROGERS. That is for what? For everything?

Dr. ZAPP. That is correct.

Mr. ROGERS. How much of that will actually be spent for communicable diseases of the $90 million?

Dr. ZAPP. Mr. Chairman, the problem with block grants is one that we have had the same difficulty as Members of Congress have had before, and that is identifying the exact uses within the States.

Mr. ROGERS. Of course. That is the point I am trying to get to. How much of the $90 million has been used?

Dr. ZAPP. We don't know exactly how the Federal funds alone are used. We do know, however, how the Federal funds plus the required matching funds are used. We have a contract with the Association of State and Territorial Health Officers to develop a reporting system to determine how much Federal, State, and local funds are used to support all State health department programs.

Mr. ROGERS. Let me tell you. I just checked to see what some plans were for these regional health plans. I find that districts in Boston, Chicago, and Seattle don't even have any plans for immunization programs. They don't even have the plans. There is no request. What do you do?

Dr. ZAPP. Certainly in a case like that the block grants are to be used for what they consider to be their highest health priorities.

Mr. ROGERS. Do they have any problem in those areas of Boston, Chicago, or Seattle? Is there any problem there?

Dr. ZAPP. I am sure that there is a problem there. I think it can be answered by two things: One is that the funds that they get out of 314(d) have their own competing priorities.

Mr. ROGERS. We are not using any partnership funds basically of the $90 million authorized for this program, are we?

Dr. ZAPP. Of the 314(d)?

Mr. ROGERS. The impression given to the committee earlier was that $90 million was available for these programs. I don't think you meant to give that. That is the impression I got and I think maybe members of the committee got. So we really are not using those funds, are we?

Dr. ZAPP. The 314(d) are a formula, a block grant, given to the States.

Mr. ROGERS. They can do anything they want with those on their own priority and most of them are going to say, "We have so many pressing problems we will never get around to a program of trying to keep people from getting these because that is not as critical as a guy

that is already sick." I realize that because we don't give them enough funds to do everything. So let us say we are not getting much out of partnership for health funds in the block grant.

Dr. ZAPP. In the 314(d). But the 314(e) is the one we are requesting an increase in the authorization level to carry out our communicable disease program.

Mr. ROGERS. So (d) is not very helpful.

Dr. ZAPP. We don't know how helpful (d) is.

Mr. ROGERS. You don't have any proof it is helpful?

Dr. ZAPP. No, nor do we have any contrary proof as far as communicable disease is concerned.

Mr. ROGERS. I have proof here because some have not even asked for money.

Dr. ZAPP. For communicable disease.

Mr. ROGERS. That is what I am talking about. So we set those aside. Now let us get to your (e).

What funding do we have in (e) and what has been your pattern in the last 3 years?

Dr. SENCER. For the immunization program?

Mr. ROGERS. Yes; and communicable disease.

Dr. SENCER. In 1971 there was $16 million made available to the States under section 314(e) for immunization programs. The following year there was $13 million. There was a planned reduction because of the fewer numbers of children that needed to be immunized against rubella.

Mr. ROGERS. Have we immunized them all?

Dr. SENCER. No, sir; but we still have $13 million for immunization programs.

Mr. ROGERS. Would that cover then all that needed to be immunized?

Dr. SENCER. This is our estimate of what could be accomplished in that year.

Mr. ROGERS. I am not saying what could be accomplished. Does that go to immunizing all the children that should be?

Dr. SENCER. No, because we had a plan that would take 5 years to reach all the children.

Mr. ROGERS. How many years have we been immunizing?

Dr. SENCER. We are now in our third year against rubella.

Mr. ROGERS. How many for measles?

Dr. SENCER. We are now funding federally supported programs for measles. We began in 1966 and we had 3 years of appropriations for measles. Then this past year we were able to reprogram money for measles.

Mr. ROGERS. How much this past year?

Dr. SENCER. $3.5 million.

Mr. ROGERS. That has been going since 1965. Have we covered all the children?

Dr. SENCER. No, sir; there are still children who have not been reached. In our 1973 request there is money for measles vaccine.

Mr. ROGERS. How much for measles vaccine?

Dr. SENCER. There is a total of $4 million for vaccines and supplies other than those related to rubella. We estimate about $3.5 million for measles; the other half million for polio.

Mr. ROGERS. Are you doing anything with mumps, diphtheria, or whooping cough?

Dr. SENCER. Since the beginning of the Vaccination Assistance Act in 1962, we have supported people in health departments whose job it has been to organize and implement the immunization program.

Mr. ROGERS. Without money to get the vaccine——

Dr. SENCER. Money is available under Children's Bureau title V funds for this, and has been historically. We did not see that we should replace money that the States have had for themselves or have available from other sources.

Mr. ROGERS. Have other sources been sufficient?

Dr. SENCER. The problem in the other vaccines is not the cost of the vaccine. Diphtheria, tetanus, and whooping cough is a vaccine that costs 2 to 4 cents per dose. The big problem is getting the children immunized rather than providing vaccine. We are encouraging the States to use the money to hire people.

Mr. ROGERS. You are telling us that the States have sufficient moneys to buy all the vaccines necessary?

Dr. SENCER. I am sure there are some States that do not.

Mr. ROGERS. Put in the record who does not. You may not have that now, I understand. But it is my understanding that they don't.

Dr. SENCER. We will furnish that information for the record, Mr. Chairman.

(The following information was received for the record:)

STATES WHICH INDICATED INSUFFICIENT RESOURCES FOR DPT VACCINE FROM STATE FUNDS

Arkansas	Maryland	Pennsylvania
California	Missouri	Texas
Delaware	Nebraska	Vermont
Florida	Nevada	Virginia
Georgia	New Jersey	Washington
Hawaii	New Mexico	Puerto Rico
Iowa	New York	Virgin Islands
Kentucky	Oklahoma	
Louisiana	Oregon	

Mr. ROGERS. Your funding is not sufficient to give them adequate funds even to do the work. Is that half a million dollars?

Dr. SENCER. That is a half million for polio vaccine.

Mr. ROGERS. How much do you give for the actual work of doing all this other vaccination?

Dr. SENCER. This comes out of the basic grant that the States have been receiving. Of the $13 million, we estimate about $7 million of that is for personnel to organize and implement immunization programs.

Mr. ROGERS. In other words, $7 million goes for personnel out of the $13 million?

Dr. SENCER. Yes, sir.

Mr. ROGERS. In 1972. And the rest is $4 million——

Dr. SENCER. It would be $6 million for the purchase of rubella vaccine and $4 million for the purchase of measles and polio vaccine.

Mr. ROGERS. That makes more than $13 million, to me.

Dr. SENCER. It is actually $17 million. There was $13 million identified under the rubella program. Then $4 million for other immunization activities—$17 million.

Mr. ROGERS. Still, if you had $6 million for—what is it, rubella?

Dr. SENCER. Could I recapitulate?

Mr. ROGERS. Surely.

Dr. SENCER. Roughly $7 million is used for personnel working in immunization programs; $6 million for the purchase of rubella vaccine; $3.5 million for the purchase of measles vaccine, and $0.5 million for the purchase of polio vaccine.

Mr. ROGERS. Is the $7 million a sufficient amount for personnel to do the work?

Dr. SENCER. I think if you put this in in the context of the other activities that a health department is going to carry out, yes. We think this past year we have seen an increase in the immunization levels of the children, particularly in the inner cities, and we think this is sufficient to accomplish worthwhile goals.

Mr. ROGERS. All that needs to be done?

Dr. SENCER. Yes, sir.

Mr. ROGERS. What are you asking for this year, then, if that is sufficient?

Dr. SENCER. In our 1973 request?

Mr. ROGERS. Yes.

Dr. SENCER. We are asking for $24.5 million for venereal disease control, $10 million for rubella, $4 million for other immunizations, and a half million for programs to prevent Rh sensitization.

Mr. ROGERS. Any polio?

Dr. SENCER. That is in the $4 million. It is roughly in the same proportion.

Mr. ROGERS. $500,000?

Dr. SENCER. Yes, sir.

Mr. ROGERS. What would the $3.5 million be?

Dr. SENCER. Measles.

Mr. ROGERS. Measles $3.5 million. Rubella $10 million.

Dr. SENCER. Which includes personnel costs, too.

Mr. ROGERS. And rubella does, too?

Dr. SENCER. Yes.

Mr. ROGERS. $7 million?

Dr. SENCER. Yes.

Mr. ROGERS. So you are going to have $3 million for vaccine?

Dr. SENCER. That is correct.

Mr. ROGERS. Are any of these carryover funds?

Dr. SENCER. There always is a small amount of carryover funds but this is new obligational authority that we are asking for.

Mr. ROGERS. What are you currently spending on VD?

Dr. SENCER. The grant budget for this fiscal year is $22.3 million.

Mr. ROGERS. $22.3 million?

Dr. SENCER. Yes, sir.

Mr. ROGERS. What did you spend the year before?

Dr. SENCER. $6.3 million.

Mr. ROGERS. $6.3?

Dr. SENCER. Yes, sir.

Mr. ROGERS. What does this program go to mainly?

Dr. SENCER. The $6.3 million that we had been providing to State and local health departments was principally for personnel involved in syphilis epidemiology and control. The new moneys that have been made available this year, the $16 million new initiative, will principally be used in gonorrhea control. There will be four major aspects of the

program in gonorrhea control. One was described by Dr. Carter, the screening of large numbers of women who are being examined for other purposes, selected epidemiologic investigations of people who are found to have gonorrhea, public education, and professional education.

Mr. ROGERS. What was the number of measles in 1969?

Dr. SENCER. The reported cases of measles in 1969 was 25,826.

Mr. ROGERS. In 1970?

Dr. SENCER. 47,272.

Mr. ROGERS. 1971?

Dr. SENCER. 75,007.

Mr. ROGERS. It has been doubling about every year. A hundred percent increase.

Dr. SENCER. Yes, sir. But if I can relate what happened in the past year it might show that the moneys that we have available have had some impact. This is a January to January count. A more appropriate way of looking at measles is in terms of when is it occurring. About the last 12 weeks of the year and the first 18 weeks of the next year is the period when most measles occurs. In that period in 1970–71 there were about 58,000 cases of measles reported, and for the same period in 1971–72 it is down to 24,000. So that in this past year when we have been able to retarget funds to purchase measles vaccine we have brought about a reduction of measles.

Mr. ROGERS. Why should there be any cases of measles?

Dr. SENCER. It would be nice to say that we could achieve this, but I think a hundred percent coverage of any population group is more than we can expect. Measles is a highly infectious disease. Even if you get to 90 percent protection you are still going to have measles occurring. I think the highest level of protection we have ever achieved with any vaccine is around 90 percent. That was with oral polio vaccine which is so much easier to give than anything we have now.

Mr. ROGERS. What happened to polio when we got 90-percent coverage?

Mr. SENCER. When we got 90-percent coverage polio practically disappeared, but polio is not as infectious a disease as measles. Measles is spread by the respiratory, throat, droplet infection. Polio is enteric spreading. It is much more difficult to spread.

Mr. ROGERS. Doesn't it require even greater effort to wipe out measles?

Dr. SENCER. Yes; it does.

Mr. ROGERS. But we are not doing it, you tell us.

Dr. SENCER. Well, I will say that between 1967 and 1970 there were 3 years in which the Federal Government did not support measles immunization programs. Beginning last year and continuing this year we are once again providing support to State and local health departments for measles vaccines.

Mr. ROGERS. Up to the amount of what?

Dr. SENCER. $3.5 million.

Mr. CARTER. Will you describe the method of immunization against measles?

Dr. SENCER. The measles vaccine is a vaccine that is injected. It is a live virus vaccine. It has a low rate of reaction. In the early days of measles vaccine there were different types used. One had a rather se-

vere reaction and it had to be given with gamma globulin. Today the measles vaccine universally used in this country does not need gamma globulin. It is a very innocuous vaccine. We recommend it to be given at 1 year of age. Earlier than that the child will have maternal antibodies and won't get a good immunological take.

Mr. CARTER. Thank you.

Mr. ROGERS. Do I understand that the figures for 1972 will be less?

Dr. SENCER. Yes, sir.

Mr. ROGERS. For the year?

Dr. SENCER. We have every anticipation that it will be; yes, sir. We not only began immunizing again last year but we are continuing this year.

Mr. ROGERS. How many susceptibles have not been immunized, do you estimate?

Dr. SENCER. In measles?

Mr. ROGERS. Yes.

Dr. SENCER. We estimate that 79 percent of the children in school age have either had measles or have been vaccinated and 64 percent of the preschoolers have been immunized or have had the disease.

Mr. ROGERS. That leaves how many million that have not? Approximately.

Dr. SENCER. About 2.5 million, sir. I must say that we have around 3.5 million new susceptible children coming in each year due to the new births.

Mr. ROGERS. So this will make about 7 million——

Dr. SENCER. Yes.

Mr. ROGERS. Susceptibles that have not been vaccinated?

Dr. SENCER. That is correct.

Mr. ROGERS. Now, is the projected program enough to cover these?

Dr. SENCER. We believe that with the percentage of people who have been participating or should be participating in federally supported programs that this is ample to provide the vaccine and the personnel to reach that; yes, sir.

Mr. ROGERS. So we should get 100 percent?

Well, I realize you can't get 100 percent but you think you could get 90?

Dr. SENCER. If we continue to increase as we have in the past year.

Mr. ROGERS. Which is what?

Dr. SENCER. Last year it was estimated in the 1 to 4 age group it was around 60 percent.

Excuse me—the figures I gave you earlier were only in central cities, Mr. Chairman. The total of this year was 66.6 in the children between 1 and 4, and 81.3 percent in the 5 to 9. I think the difference points out that it is in the central city that we have our major problems.

Mr. ROGERS. Do you immunize above age 9, or should we?

Dr. SENCER. Above age 9 most children either have had the disease or have already been immunized. So we are concentrating on the unimmunized preschoolchild.

Mr. ROGERS. Is this for rubella?

Dr. SENCER. This is for regular measles.

Mr. ROGERS. What is the situation on rubella?

Dr. SENCER. With rubella we have reached about 73 percent of the school-age children, prepubertal school-age children.

Mr. ROGERS. What about preschoolers?

Dr. SENCER. Preschoolers, 47 percent. I think this is to be predicted because our strategy of control was to aim at the school-age child in the first years of the rubella program because this is the child who could spread it to other children and on to the parents.

Mr. ROGERS. So we still have more that have not been receiving it than have received it.

Dr. SENCER. We have more preschool children that have not received it as yet.

Mr. ROGERS. Let me ask you—the doctor discussed with you the syphilis. Did you say this was going up or down?

Dr. SENCER. The past 2 years there has been a slight increase in infectious syphilis.

Mr. ROGERS. What funds have been going to that?

Dr. SENCER. The budget for syphilis control has been constant at $6.3 million for the past 3 years.

Mr. ROGERS. What do you project for syphilis?

Dr. SENCER. We project the same amount for syphilis. We anticipate that the gonorrhea program will also impinge upon syphilis because the recommended dosage of penicillin now for the treatment of gonorrhea will be adequate to abort infectious syphilis if it is incubating. So we think we will have a concurrent impact upon syphilis.

Mr. ROGERS. What are the cases of syphilis this year?

Dr. SENCER. Around 20,000 reported infectious cases of syphilis.

Mr. ROGERS. About gonorrhea, what were the gonorrhea cases in 1969, reported cases?

Dr. SENCER. In 1969 the reported cases of gonorrhea were 494,227.

Mr. ROGERS. In 1970?

Dr. SENCER. 573,200.

Mr. ROGERS. In 1971?

Dr. SENCER. 624,371.

Mr. ROGERS. Do we have any estimate for this year so far, projection of what it may be?

Dr. SENCER. The projection is that it will be at least that high. As we get our program started we anticipate the cases to go up. Whenever you start to emphasize a disease and go out and start finding it the number of reported cases are going to go up. So, I would say that the increase this coming year is expected and is to be considered as part of our activities rather than a continued increase in the disease.

Mr. ROGERS. What are the most severe communicable diseases as far as infecting numbers?

Dr. SENCER. In numbers, gonorrhea is the most commonly reported communicable disease today; staphylococcus sore throat second; mumps third; syphilis, fourth.

Mr. ROGERS. Do you think syphilis has been going up because the program was cut out for a while?

Dr. SENCER. We feel that the increase in the early 1950's was due to a combination of lack of support of the program and also complacency. There has been continued support of the syphilis program and it is still going up. We think that this is perhaps due to personnel limitations.

Mr. ROGERS. Have you had a specific grant fund program for the control of gonorrhea?

Dr. SENCER. No, sir; not until this year.

Mr. ROGERS. No funds were requested from the bill we passed covering the last 2 years for that; is that right?

Dr. SENCER. In 1972, sir, the $16 million increase is under the authority of section 317, the bill that was passed 2 years ago.

Mr. ROGERS. What I am saying is that from the authorizations in the bill we passed, you asked for what, $2 million?

Dr. SENCER. That was the year before last, sir.

Mr. ROGERS. Only $2 million?

Dr. SENCER. Yes.

Mr. ROGERS. You are asking for this coming year, you mean?

Dr. SENCER. For the current fiscal year $16 million for gonorrhea control and $4 million for immunization, which is under the authority of the communicable disease bill as passed by this committee.

Mr. ROGERS. In TB, is the death rate up?

Dr. SENCER. No. The death rate in the general population is 2.7 percent.

Mr. ROGERS. Since 1953?

Dr. SENCER. In 1953 the death rate was 12.4. Today it is 2.7.

Mr. ROGERS. How many susceptibles to TB do you estimate are infected and should receive treatment?

Dr. SENCER. Not all people who are infected we believe need treatment at the present time, but we estimate that there are about 16 million people in the United States who have been infected at one point in time. Those who have been infected recently we feel should receive preventive treatment to prevent progression of their infection into active infectious disease that could then infect other people.

Mr. ROGERS. How many do we treat?

Dr. SENCER. This past year there were some 35,000 new active cases of tuberculosis reported and under treatment. In addition to that, there are about 4,000 people who have had the disease in the past who have a reactivation. It is about 39,000 people who are infectious and being treated for that purpose.

Mr. ROGERS. 39,000?

Dr. SENCER. 39,000; yes, sir.

Mr. ROGERS. What are you doing for the 14 million that are infected? Anything?

Dr. SENCER. There is no direct Federal program.

Mr. ROGERS. We have no program?

Dr. SENCER. There are State programs that are finding these people who have been recently infected. We are finding contacts of cases of tuberculosis.

Mr. ROGERS. We are not giving them any support?

Dr. SENCER. Dr. Zapp mentioned in 1970 that $18 million of partnership money was transferred to the bloc grant. The States were asked to set their priorities on this and use it for tuberculosis control activities in their State. In addition, recognizing there were some problem areas where they would be getting a reduction in funds we did continue to make available support under 314(e) to selected communities to phase out until they could get local funding to carry on their programs.

Mr. ROGERS. So you are saying that $18 million was spent to get to those are infected but did not have active tuberculosis?

Dr. SENCER. I think this goes back to Dr. Zapp's earlier testimony. We have at the present time no way of knowing how much of that $18 million has continued to go for tuberculosis control.

Mr. ROGERS. We don't know.

Dr. SENCER. That is right.

Mr. ROGERS. Probably not much if we don't know it.

Dr. ZAPP. Of course, Mr. Chairman, right now we don't really have an accaurate fix on how any of the 314(d) or a substantial amount of it is being used.

Mr. ROGERS. Don't you have plans to get it?

Mr. DUNCAN. State plans have to specify the particular area in which the money is to be utilized.

Mr. ROGERS. You don't have any health plan? You just give them a bloc without any plan? I thought we required a health plan to come in to you and be approved.

Mr. DUNCAN. The plan itself is no longer submitted. The plan has to be available.

Mr. ROGERS. Who decided there would not be any submission of the plans after the law says we want a plan? Did you design it or Mr. Wilson, or the Secretary, or who?

Mr. DUNCAN. The plan is available, Mr. Chairman.

Mr. ROGERS. It does not do much good, does it, if you don't look at it?

Mr. DUNCAN. They are looked at.

Mr. ROGERS. Who is looking at them?

Mr. DUNCAN. The people in our regional offices, sir.

Mr. ROGERS. This is unbelievable.

Dr. ZAPP. Mr. Chairman, they are not reviewed on the national level. The States do have to prepare them and have them available for our regional offices. The theory of a bloc grant for a purpose as broad as health to a State is that they themselves through their own council and review set the priorities that are most needed within their State.

Mr. ROGERS. And to plan for it and to set forth a plan and they submit it to you and if it is logical you give them the bloc grant. It also is supposed to help us to decide whether we need supplemental funds, whether we need categorical programs, also to see what they are doing with that money. How will we ever know if they are getting at this problem?

Dr. ZAPP. We share the dilemma of the committee.

Mr. ROGERS. There should not be a dilemma. The law says it.

Dr. ZAPP. I don't really think that even with a State plan filed by categories that it is that simple.

Mr. ROGERS. You have how many employees?

Dr. ZAPP. In the Department?

Mr. ROGERS. Yes.

Dr. ZAPP. About 103,000 or 104,000.

Mr. ROGERS. You have to contract out to find out what a State is doing with a health plan? Fifty plans to look at and we can't find out with as many employees as we have? How many do you have in HSMHA?

Mr. DUNCAN. About 26,000.

Mr. ROGERS. You mean you could not take 50 of them and let them look at these plans? I think the committee is going to have to go into this in some detail. I won't do it now.

Dr. ZAPP. I might say, Mr. Chairman, that the group we contracted with is the Association of State and Territorial Health Officers who are deeply involved with the administration of these State programs. From our standpoint it seems logical to use somebody who is familiar with the local and State agency operations develop a uniform system to describe the services rendered by State health departments and their costs.

Mr. ROGERS. I think for anyone in health it would not take them long to just look at a plan to determine what their problems are, if they are spending this money to cover them all, or whether they are not.

Dr. ZAPP. We find many things might look good on paper. We should have somebody familiar with these programs areas who can tell us actually what the State program and needs are. Our purpose in doing this was to have this information available. We felt that it was information that both we and the committee will need.

Mr. ROGERS. We are going to need some information.

Let me ask you this: I understand we gave some funds to Los Angeles County for immunization. Is that correct?

Dr. SENCER. Yes, sir.

Mr. ROGERS. Under what program was that and how much?

Dr. SENCER. The program in Los Angeles County is a subpart of the California immunization program. So, I won't have the actual amount that went to Los Angeles. The State of California's immunization grant in 1972 is $1.5 million.

Mr. ROGERS. What were our funds to them?

Dr. SENCER. A million and a half dollars.

Mr. ROGERS. Directly to Los Angeles or to the State?

Dr. SENCER. This was to the State of California. Then they subproject that.

Mr. ROGERS. We don't know how much——

Dr. SENCER. I can get it for you.

Mr. ROGERS. Did they have an epidemic there?

Dr. SENCER. Yes, sir; they have recently had an epidemic of measles in the city of Los Angeles.

Mr. ROGERS. Did you move in any personnel?

Dr. SENCER. We have our own staff already assigned to Los Angeles. I think we did send two additional people to help them.

Mr. ROGERS. Will you let us know?

Dr. SENCER. Yes, sir.

(The following information was received for the record:)

FEDERAL FUNDS PROVIDED TO THE LOS ANGELES AREA FOR IMMUNIZATION PROGRAMS

Of the $1.5 million awarded to California in 1972, $640,915 was provided to Los Angeles through a subproject. In addition, the State of California has sufficient vaccine grant resources to provide Los Angeles with enough vaccine to immunize its susceptibles to measles, polio, and rubella.

The 75,000 doses of measles vaccine administered by the Los Angeles County Health Department during this epidemic was provided by the immunization grant.

The Center for Disease Control has three immunization employees (two Public Health Advisors and one medical officer) assigned to the Los Angeles County Health Department, who assisted in the epidemic control program. A Public Health Advisor assigned to the State Health Department office in Berkeley was also brought in to assist in controlling the epidemic. Jet injector equipment was sent from CDC for epidemic control use.

Los Angeles County will receive $21,000 of the $65,000 being awarded to the State of California for additional immunization activities.

Mr. ROGERS. I understand the county gave some 75,000 shots and maybe 40,000 were given by private physicians. Would that he correct?

Dr. SENCER. Yes, sir.

Mr. ROGERS. I understand there are still some 170,000 susceptibles in the county and the county is out of money. Are we doing anything about that?

Dr. SENCER. Yes, sir. There is a grant reguest in the regional office that will be funded for additional immunization activities in the State of California to the extent of another $65,000.

Mr. ROGERS. What is the status of it?

Dr. SENCER. It should be awarded within the next 2 weeks.

Mr. ROGERS. Do you have the funds?

Dr. SENCER. Yes, sir. They have been suballocated to the regional office.

Mr. ROGERS. Do they have a problem there where nurses won't give shots without a physician?

Dr. SENCER. I can't answer that, sir; I don't know.

Mr. ROGERS. I understand that is true, and the State prohibits medics from administering shots. Is that correct?

Dr. SENCER. Again I plead ignorance.

Mr. ROGERS. I would appreciate your checking that and letting us know.

Dr. SENCER. Yes, sir.

(The following information was received for the record:)

CALIFORNIA POLICY RE NURSES AND PARAMEDICS ADMINISTERING VACCINE

California does not prohibit nurses or other paramedical personnel from administering vaccine. However, as a matter of policy, California and a number of other States require that a physician be on the premise when vaccine is being administered. This policy does not seriously hamper immunization programs. It does occasionally present some difficulties in scheduling special immunization clinics in schools and other similar locations.

Mr. ROGERS. Are polio deaths up?

Dr. SENCER. The polio cases are down. Death information unfortunately runs behind. We do not have information on polio deaths for the last 3 years.

Mr. ROGERS. For the last 3 years?

Dr. SENCER. That is correct.

Mr. ROGERS. Why is that?

Dr. SENCER. Mortality records are collected by a different system than our surveillance information.

Mr. ROGERS. What do we have to do to find out who is dying around here?

Mr. NELSEN. Read the weekly papers.

Mr. ROGERS. Isn't there an office of vital statistics in almost every State where they keep death statistics?

Dr. SENCER. They keep deaths. These are collected by the National Center for Health Statistics. The reports run about two——

Mr. ROGERS. To 3 years behind.

Dr. SENCER. Yes, sir.

Mr. ROGERS. That is unbelievable, too. Can anything be done about that, Dr. Zapp?

Dr. ZAPP. I would certainly hope so.

Mr. ROGERS. We could have the entire population wiped out before we knew it, 3 years later. Ancher thinks it will be in the newspapers. I hope so—an alert press.

Mr. DUNCAN. We are requesting additional support to catch up and keep abreast.

Mr. ROGERS. How much?

Mr. DUNCAN. I am not certain of the amount.

Dr. SENCER. $10 million.

Mr. ROGERS. It ought to be done. We ought to have the figures on this.

Dr. ZAPP. We ourselves are not pleased with the lag time on some. Some of them are very good. Others are up to 3 years behind. I think that depends on the severity of a certain disease at that time, perhaps.

Mr. ROGERS. Would you let us know the number of persons under age 20 who have not received polio vaccine in the United States to date?

Dr. SENCER. Yes, sir. With no polio vaccine under the age of 20?

Mr. ROGERS. Yes. Under age 1 how many have not received polio vaccine?

Dr. SENCER. Under 1 there are 8.6 percent who have received no polio vaccine. Excuse me, we do not collect polio information under the age of 1. The Bureau of the Census gives us 1 to 4 and only 8.6 of the children between 1 and 4 have had no vaccine. In the total population under the age of 20 only 4.2 percent have not had any polio vaccine.

Mr. ROGERS. Which is about how many?

Dr. SENCER. 4.2 percent of 73 million is 3.1 million.

Mr. ROGERS. 3.1 million. Will the $500,000 you have for polio assure coverage of this?

Dr. SENCER. It won't assure coverage of that. We are concentrating this on the preschool children who is the most susceptible at the present time, and most in need of it.

Mr. ROGERS. Our bells have rung here and I have a lot of questions that we need to go into.

Mr. NELSEN. Mr. Chairman, one question before we stop for the quorum call. I am curious, so many times we make requests of our Federal agencies that go beyond the dollar possibility of an agency to perform. Many times our authorizations are liberal but the appropriation is substantially cut.

Do you find that the dollars that the Congress has given you are adequate to do what we on this commitee might expect of you? Can you perform to the extent that would appear to be the wish of this committee with the dollars that you have to work with, and the personnel?

Dr. ZAPP. We think that we can, Mr. Nelsen. It is always difficult in a department as large as ours where we do have situations with some authorities that are open ended and difficult to predict. And again with the many, many authorities that we have that differ between projects and formula grants.

Mr. NELSEN. I remember a few years ago a meeting at the White House where HEW reported that they were shifting from categorical approach to an allocation of funds to the States and letting the States select the areas most in need and then to proceed in that manner. I remember how pleased we were to see this new approach. Then, of course, in our legislation we did require a State to submit a plan and on the basis of the plan their activities were funded.

I just realize, as one member of this committee, how tremendous this whole operation is and what a tremendous demand it is on the gentlemen sitting before us to do the various things they must do and try to do. So we want to be compassionate too about your efforts and we appreciate the fact that you are here.

Maybe we had better get over and answer that quorum call.

Mr. PREYER. On the question of funding, you point out that the savings on the tuberculosis program runs something like $500 million. I would like to see you list the savings, if you have this available, for each of these programs, so that we get this program in the posture of an investment with an emphasis on what is saved rather than on what it costs. When we request funds we are in a much stronger position if we have the figures to show that we are saving millions and millions of dollars, not that we ask for your consideration in giving us $5 million more for this.

Dr. ZAPP. We have them. I assume what you are asking for is not the ones we quoted as justification for those on TB but what we have on the other communicable disease program.

Dr. SENCER. We have that on rubella and measles.

Mr. PREYER. Do you know that figure offhand?

Dr. SENCER. We estimate that the 1964 epidemic of rubella that resulted in around some 20,000 children who were severely handicapped is going to cost the country about $1,600 million. So that we are, by preventing congenital rubella, saving a great deal of money.

Mr. PREYER. That is a small investment to reap that kind of reward. Thank you.

Mr. ROGERS. You know in section 313, which has been in the law for some time, it says that to secure uniformity in the registration of mortality, morbidity and vital statistics the Secretary shall prepare and distribute suitable and necessary forms for collection and compilation of such statistics which shall be published by the Secretary.

Dr. ZAPP. Yes. That is our National Center for Health Statistics. As I said a minute ago, Mr. Chairman, we ourselves feel that the process is not at the state of the art that we would like to see—are not as contemporary as we would like to see it. That is the reason we have requested additional funds to update it. We are continually getting new categories included and asking for the States to comply with such as in the case of sudden infant deaths and other things.

Mr. ROGERS. You know what is going to happen. I think that in some of these problems where it is a responsibility for health officers and we have some responsibility for these programs, it is not going to be long before you are going to have parents suing public health doctors or program managers of the Department for retardation in their children or for deaths because they have not carried out the law. I think the Department ought to look into this soon because it is going to be a responsibility here that could well be challenged in the courts, I believe.

Dr. ZAPP. Mr. Chairman, we take our public health responsibilities very seriously. Mr. Nelson brought up the question a minute ago, Do we have adequate personnel or dollars? The health dollars in HEW in 1969 were $11.7 billion. In 1971 it was up to $14.5 billion; 1973, we anticipate it to be up to $18.1 billion.

Even with that kind of increase in the short period of time we still realize that we can't do everything at once. It is a matter of working

with the committees and working with the competing priorities and the mechanisms that we see available to get the kind of payoff that Mr. Preyer was talking about.

Mr. CARTER. I would like to ask a couple of questions. One of them is, What part of this appropriation you are talking about is for preventive medicine for public health, really?

Dr. ZAPP. I would say, without getting into actual figures, a small amount, Dr. Carter.

Mr. CARTER. I am a little bit worried that our liaison between the U.S. Public Health Service and our State public service officials is not good enough and that our health officers perhaps have not been kept on the ball as much as they could be throughout our country. I have noticed this. I regret to say that in the State with which I am most familiar they are not doing as good work as they did a few years ago.

Mr. ROGERS. If we can come back right after we answer this call I think we can finish you up quickly. I think there are two doctors that have to leave here by 1 o'clock, Dr. Parrott and Dr. Carver. It is my understanding you have to leave by 1 o'clock. We will go and try to come back and finish up as rapidly as possible. We will try to get you out of here by that time.

The committee will stand in recess for 10 or 15 minutes.

(Brief recess.)

Mr. ROGERS. The subcommittee will come to order.

I believe you said that we had $16 million VD and $4 million immunization against measles.

Dr. SENCER. We have new money in the 1962 budget.

Mr. ROGERS. 1972.

Dr. SENCER. Excuse me, 1972, under authorization of the Communicable Disease Act with $16 million for gonorrhea control and $4 million for immunization against measles and polio.

In the same budget there is an additional $6.3 million for syphilis and $13 million for rubella.

Mr. ROGERS. Were any of these left over?

Dr. SENCER. No, sir.

Mr. ROGERS. What about 1973?

Dr. SENCER. Our 1973 budget—we are requesting $24.8 million for venereal disease, $10 million for rubella, $4 million for other immunizations, and a half million dollars for Rh sensitization.

Mr. ROGERS. Will any of those moneys be left over from 1972?

Dr. SENCER. No, sir; that will be all new obligational authority.

Mr. ROGERS. You will have no moneys left over from 1972 then?

Dr. SENCER. There will be no moneys left over. The money will be in the States being used in the next year because we are just now obligating the money to the States.

Mr. ROGERS. In other words, you are just now getting out the 1972 money?

Dr. SENCER. The $16 million and the $4 million is in the process now of being obligated.

Mr. ROGERS. What were they using before this? You had no program?

Dr. SENCER. We had the $6.3 million for syphilis.

Mr. ROGERS. Was that left over from anywhere?

Dr. SENCER. No, that was original money under section 314 authority which was obligated in July. We had $13 million of rubella money

which was obligated in July. Then there was an additional $16 million that had not been in the 1971 budget and an additional $4 million which had not been in the 1971 budget that we could not obligate until we got off the continuing resolution and got guidelines published in the Federal Register.

Mr. ROGERS. So those previous funds had been left over from 1971?

Dr. SENCER. No, sir. They were new moneys in 1972 but we could obligate them because we were on a continuing resolution and that money had shown in the year before also.

Mr. ROGERS. Were any of those funds (d) funds?

Dr. SENCER. None of the funds I am referring to are (d) funds. The $6.3 million was project grants under section 314(e); $13 million were project grants for rubella under 314(e).

Mr. ROGERS. Could they buy the vaccines under (d)?

Dr. SENCER. If they desired to they could; yes, sir.

Mr. ROGERS. As a matter of fact they do not.

Dr. SENCER. We don't have information on that. We do know they buy considerable vaccines with title V money.

Mr. ROGERS. Can you break out for me in 1972 and 1973 what will be going for rubella and for measles?

Dr. SENCER. In 1972, $13 million for rubella, $3 million for measles, and a half million dollars for polio.

In 1973, $10 million for rubella, $3.5 million for measles, and a half million dollars for polio.

Mr. ROGERS. What do we do when you have a measles epidemic—say for instance when it happened in St. Petersburg—what is the reaction?

Dr. SENCER. Once people recognize that there is an epidemic of measles and ask for assistance we can provide them with additional measles vaccine out of an epidemic stockpile we maintain. We can provide injectors so that there can be rapid immunization, we don't have to worry about needles and syringes. We can also provide them with epidemiologists and operational people to help control it.

Mr. ROGERS. Is that what you have done?

Dr. SENCER. We have done this on numerous occasions.

Mr. ROGERS. Did you do it in Florida?

Dr. SENCER. We did it in St. Petersburg, yes.

Mr. ROGERS. Over what period of time did you participate?

Mr. SENCER. The unfortunate thing in St. Petersburg was that the epidemic was not recognized promptly so that we got in toward the end of it. I think our staff was there about 10 days.

Mr. ROGERS. Who is supposed to recognize it? What triggering device do we have?

Dr. SENCER. The triggering device is the reporting of cases to the local health department by the physicians who are seeing them. If the cases aren't reported, there is no way of recognizing that there is a sudden increase beyond that which is expected.

Mr. ROGERS. Is that a requirement that these be reported?

Dr. SENCER. Every State has requirements on reporting a variety of communicable diseases. There is no way in which these can be enforced. It is dependent upon good educational activities by the health officials to encourage the private physicians to report.

Mr. ROGERS. Why don't we require it? Is there any reason why we should not require reporting of communicable diseases?

Dr. SENCER. The Public Health Service Act says that there are certain diseases that can be required to be reported to us because of interstate transmission. But when it comes to dealing with States' public health services, the act says that the Department shall cooperate with the States. We do not have a direct authority to require something such as this.

Mr. ROGERS. So we cooperate by finding out nothing?

Dr. SENCER. I think, sir, St. Petersburg may be atypical. We have on numerous occasions been called in at the outbreak and shown how prompt immunization of all the children in a school, for example, will stop the epidemic right at that point in time.

Mr. ROGERS. I would like the Department to submit some language to give us some authority to require reporting of communicable diseases.

Dr. SENCER. We can require those diseases to be reported by the States to us, but we have no way in which we can require the local physician to report to the State.

Mr. ROGERS. Maybe we ought to require, make up a Federal requirement. Is there anything unreasonable about that? The regulation would be in carrying out the authority that all communicable diseases be reported promptly to public health officials. The Secretary could then designate the public health officer in the State to assemble that information, or whatever it may be.

Dr. ZAPP. I think Dr. Sencer's point was the Federal override of either State enactment or nonenactment in a case like this. It is how we would by-pass authorities of the State to require the locality——

Mr. ROGERS. We are not getting it in time. That is just what we have said. There is no way for the State to require, or at least they are not requiring, private physicians to report, to get a handle on this thing before it gets out of hand.

For instance, did they recognize it quickly enough in Los Angeles?

Dr. SENCER. There were a good number of cases before help was requested.

Mr. ROGERS. In other words, it should have been recognized earlier.

Dr. SENCER. But I am not sure, Mr. Chairman, that there is any way that a requirement can make a diagnosis. We see this frequently happening in the venereal disease where there may be a requirement that a case be reported. It is just not diagnosed by the physician. It is treated as a nonspecific situation.

Mr. ROGERS. I understand if they don't know what the disease is, they can't report it. I wouldn't expect that. But if it is recognizable, and I think that most people could recognize measles, could they not?

Dr. SENCER. Most people could. I am much more in favor of trying to intensify our educational efforts to make physicians realize the importance of reporting.

Mr. ROGERS. I understand. That is good. It may come 10 years from now. You may get them all educated but I doubt it. All we have to do is write a provision in law and say that communicable diseases such as measles, syphilis, or gonorrhea shall be reported to public health officers in a plan or in accordance as set forth by the Secretary of HEW, and for anyone who does not report I would not mind putting a civil penalty on it.

Dr. SENCER. We do have that requirement for States to report to the Federal Government that which is reported to them.

Mr. ROGERS. I understand that, but they are not getting the reports they need. So we have an epidemic in St. Petersburg that does not get handled promptly.

Dr. Carter.

Mr. CARTER. This brings up quite a problem, of course. If you are required to report such things as gonorrhea and syphilis by name——

Mr. ROGERS. I did not say by name. I said by number of cases.

Mr. CARTER. That would be fine. But if you do it by name, it would do great harm to many innocent people.

Mr. ROGERS. I would agree. I don't think names are necessary.

Mr. CARTER. I agree with that. In most States they have had this plan. Each week in each little town in Kentucky the doctor gets a sheet of paper and he puts down the number of communicable diseases there for that particular week. It goes all over the State. Then you have your health office in each county seat compile this and send it in to the State Health Department, then here to the people in Washington. Some doctors are lax in filling these forms out. I would hate to see a small civil penalty given.

Mr. ROGERS. I do not think it would be necessary. I think this would be enough encouragement for them to do it.

Mr. CARTER. Maybe we should work it the other way and give him a little reward for doing this.

Mr. ROGERS. We will give him a star if he lets us know in time.

Mr. CARTER. I would suggest that rather than a penalty. It would be rather difficult to prosecute him, I think. He might say it was a misdiagnosis or something like that.

Thank you, Mr. Chairman.

Mr. ROGERS. If that is so, we might have to take it up with the medical society and get some quality control, Doctor.

We would like to see some language submitted by the Department on that so that we can see what plan can be worked out. We ought to be able to get proper reports. We ought to know sooner than 3 years later how many people have died from what diseases. I think this could easily be done.

Mr. ROGERS. Are there any further questions?

Thank you so much for being here. There may be some additional questions we will want to get answered for the record. I think it would be well for you to give us the picture of funding and the shifts of funds and the carryovers in our communicable disease programs.

Dr. ZAPP. We will be pleased to, Mr. Chairman.

(The following information was received for the record:)

APPROPRIATIONS REQUESTED UNDER SECS. 314(e), 317 AND PUBLIC LAW 91-695—1971, 1972, and 1973

[In thousands of dollars]

Appropriation	1971		1972			1973, sec. 314(e) estimate
	Sec. 317	Sec. 314(e)	Public Law 91-695	Sec. 317	Sec. 314(e)	
Health services delivery:						
Comprehensive health centers		65,918			88,618	[1] 100,200
Family health centers					13,000	16,000
Others		2,295			2,295	
Total, health services delivery		68,213			103,913	116,200
Preventive health services:						
Disease control:						
Rubella		16,000		3,213	9,787	10,000
Other immunization				4,000		4,500
Veneral diseases		6,300		16,000	6,300	24,800
Tuberculosis	$2,000	3,300				
Subtotal	2,000	25,600		23,213	16,087	39,300
Community environmental management:						
Rodent control		15,000			15,000	15,000
Lead-based paint poisoning			6,500			8,500
Subtotal		15,000	6,500		15,000	23,500
Total, preventive health services	2,000	40,600	6,500	23,213	31,087	62,800
Total	2,000	108,813	6,500	23,213	135,000	[2] 179,000

[1] Includes $20,000,000 of projects to be transferred from OEO in 1973.
[2] Current authorization for 314(e) in 1973 is $157,000,000.

SEC. 314(d)—HEALTH SERVICES DELIVERY ALLOCATIONS OF GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES [1]

	1971 actual	1972 allocation	1973 estimate
Alabama	$1,787,800	$1,723,400	$1,689,500
Alaska	388,100	394,100	397,600
Arizona	918,600	933,600	952,200
Arkansas	1,143,500	1,111,900	1,085,900
California	6,539,900	6,662,100	6,753,800
Colorado	1,030,300	1,063,300	1,081,200
Connecticut	1,233,000	1,237,600	1,242,900
Delaware	476,200	477,700	479,400
District of Columbia	543,600	530,700	516,600
Florida	2,561,700	2,675,100	2,767,600
Georgia	2,074,400	2,023,400	2,011,200
Hawaii	569,000	555,100	548,600
Idaho	580,200	572,900	572,000
Illinois	3,839,900	3,845,300	3,845,200
Indiana	2,062,300	2,077,000	2,113,800
Iowa	1,278,200	1,284,600	1,292,800
Kansas	1,111,700	1,090,500	1,072,000
Kentucky	1,569,700	1,559,200	1,557,500
Louisiana	1,774,700	1,743,800	1,716,600
Maine	670,400	673,700	672,000
Maryland	1,540,500	1,580,100	1,599,400
Massachusetts	2,081,400	2,139,800	2,149,800
Michigan	3,213,600	3,223,600	3,289,500
Minnesota	1,587,000	1,610,800	1,627,100
Mississippi	1,365,200	1,302,400	1,243,200
Missouri	1,938,500	1,951,800	1,950,100
Montana	557,000	557,600	557,300
Nebraska	811,400	812,600	821,600
Nevada	446,200	452,600	459,000
New Hampshire	551,900	559,500	568,400
New Jersey	2,597,300	2,597,100	2,589,400
New Mexico	689,600	693,200	690,200
New York	6,063,300	6,011,200	5,976,200
North Carolina	2,337,200	2,272,700	2,227,000
North Dakota	536,900	533,900	542,400
Ohio	3,949,000	3,921,000	3,919,000
Oklahoma	1,263,400	1,264,800	1,260,400
Oregon	1,009,000	1,026,300	1,049,400
Pennsylvania	4,360,800	4,351,000	4,310,800
Rhode Island	607,300	617,500	624,500
South Carolina	1,422,200	1,364,500	1,332,200
South Dakota	546,900	551,600	552,100
Tennessee	1,887,800	1,846,800	1,825,700
Texas	4,389,800	4,376,200	4,380,500
Utah	698,300	702,500	710,600
Vermont	458,700	461,600	465,600
Virginia	1,995,300	1,979,200	1,960,000
Washington	1,428,500	1,442,500	1,454,700
West Virginia	1,042,200	1,017,200	977,400
Wisconsin	1,767,800	1,822,700	1,857,500
Wyoming	413,300	418,700	420,000
Guam	351,500	307,700	304,000
Puerto Rico	2,063,300	2,109,500	2,058,500
Virgin Islands	265,700	265,700	265,700
American Samoa	265,700	265,700	265,700
Trust Territory of the Pacific Islands	443,300	453,400	446,700
Total	89,100,000	89,100,000	89,100,000
Evaluation amount [2]	900,000	900,000	900,000
Grand total	90,000,000	90,000,000	90,000,000

[1] Allocations are awarded to States based on population and per capita income with a minimum program requirement.
[2] Authorized by Public Law 91-296.

Mr. ROGERS. Thank you so much. We appreciate your presence here today.

I would like to know what is happening in State plans, too, if you would let us know, get someone to look at them.

Mr. DUNCAN. We have a program which we are working on to get at that kind of information.

(The following information was received for the record:)

The State Plan for Public Health and Mental Health Services Under Section 314(d) of the Public Health Service Act

The Comprehensive Health Planning and Public Health Services Act of 1966, amending the Public Health Service Act, was enacted with the objective of promoting and assuring the highest level of health attainable for every American. The 314 Sections of this Act established the authority for providing support for comprehensive health planning and comprehensive health services, and is known as the "Partnership for Health" program. Under Section 314(d), formula grants are awarded to State health and mental health authorities for public health services, including the training of health personnel. Such funds are not restricted to use in meeting specific disease problems; they are also meant to offer the States an opportunity to initiate new and different methods of providing health protection where innovation is needed, particularly where health services cannot be supported with existing State or local funds. They may also be used, of course, to support previously-established health services.

In order for the Secretary to be fully aware of the uses to which this grant money is put, and to administer the requirements of the Act and the regulations, the mechanism of a State plan is mandatory.

Under the requirements of the Act, an annual State plan must be submitted to the Secretary. The plan contains detailed and specific information about policies, procedures, and assurances pertaining to the services supported by the State health or mental health agency's annual allotment of Federal funds under Section 314(d) plus the necessary amount of State or local, public or private matching funds. The State agency has the option of including as much of its program as it wishes beyond those services which are supported by the Federal funds made available under Section 314(d) and the required matching funds. The State agency also has the option of supporting regular, ongoing programs or new, innovative or developmental activities on either a time-limited, project basis or on a continuing basis under the State plan.

Prior to the passage of Public Law 89–749, the States were required to report the use of Federal funds on a program-by-program basis in each of nine categorical formula-grant areas. This requirement was changed with the introduction of 314(d) when formula grants were consolidated into a block grant program. Thus, as of Fiscal Year 1968, the funds reported as budgeted or expended by State health programs have been a single figure representing 314(d) funds and/or all other monies in any combination.

A simplified approach to the submission of a State plan is now used. Starting with Fiscal Year 1972, the State plan approach provides for the "incorporation by reference" of the documents required by the law and regulations. Simply stated, this means that documents incorporated by reference become a part of the State plan as though fully set forth therein, but are retained in the State agency offices after being reviewed there by Regional Office staff.

Each State plan is reviewed by the appropriate Regional Office of the Department of Health, Education, and Welfare, and approval is granted or suggestions are made for modifications. Upon approval, the State agencies are able to meet the requirements of the Act and regulations by submitting a State plan certification, indicating that all required documents have been reviewed and accepted as a part of the State plan. A State plan budget in summary form is also submitted annually, containing only that information which is essential for award of the allotment of Federal funds to the State agency.

With the adoption of the simplified State plan system, both the Health Services and Mental Health Administration and the State health and mental health agencies recognized that it would be necessary for the State agencies to submit, upon request, certain information to assist HSMHA with program planning, technical assistance, and budget support. Some of this information will be submitted by the State health and mental health agencies in a State Operational and Planning Information Document currently being developed by the Health Services and Mental Health Administration. As a part of this document, it is planned to have the State agencies submit (a) a list of programs, projects or activities to be supported under the Section 314(d) State plan; (b) the total amount budgeted for each; (c) a brief description of new, developmental or innovative services; and (d) a description of the methods by which services under the plan will be evaluated to determine whether specific objectives have been achieved. Annual progress reports will be an integral part of this document.

It is emphasized that the information provided in the accompanying table relative to State plan budgets in Fiscal Years 1968 through 1972, deals *only* with those programs supported under this plan, i.e., 314(d) funds and the required matching funds. This information does not show total State health or mental

health department operations. Consequently, fluctuation of amounts reported under this State plan in any given program or classification should *not* be assumed to reflect increases or decreases in the State agency's total support of any given program or program area.

FEDERAL, STATE, AND LOCAL, PUBLIC AND PRIVATE FUNDS BUDGETED IN STATE PLANS FOR PUBLIC HEALTH SERVICES BY HEALTH PROGRAM AREAS [1]

FISCAL YEARS 1968, 1969, 1970, AND 1971—SEC. 314(d), PUBLIC HEALTH SERVICE ACT

Health program area	Amount budgeted fiscal year— 1968 [2]	1969 [3]	1970 [4]	1971 [5]
Alcoholism	$55,500	$663,888	$1,040,306	$1,675,566
Cancer	4,472,806	3,977,600	3,523,699	3,715,158
Chronic disease	19,382,750	16,485,565	10,558,364	9,293,210
Chronic disease, chronic illness, and aging [6]	18,839,992	15,352,782	10,131,995	7,733,348
Diabetes	189,172	239,507	227,876	188,778
Neurological and sensory	0	193,583	198,493	365,221
Nursing home services	353,586	699,693	0	1,005,863
Communicable diseases	26,153,218	28,240,106	44,345,575	38,605,784
Communicable diseases [6]	14,498,784	9,248,433	11,656,699	11,798,094
Epidemiology	([7])	835,618	276,885	1,990,568
Tuberculosis	11,654,434	17,930,513	25,867,226	23,468,742
Venereal disease	([7])	225,542	6,544,765	1,348,380
Dental health	3,071,293	3,897,793	3,336,478	2,322,741
Environmental health	20,668,002	32,744,571	50,008,111	38,983,026
Accident or injury prevention	([8])	1,075,365	207,644	168,642
Environmental health [6]	[9] 13,250,088	14,187,750	16,995,959	19,969,187
Food and drugs	1,597,903	5,369,686	11,917,719	4,602,989
Occupational or industrial health	([8])	2,642,413	2,618,333	3,083,574
Radiological health	3,982,743	2,777,858	2,542,047	2,089,339
Sanitary engineering	1,552,891	6,131,581	12,493,752	8,657,590
Vector control	284,377	559,918	3,232,657	411,705
General	120,044,720	141,519,791	113,814,330	170,732,306
Clinics	455,001	404,434	792,853	535,613
Drugs	134,000	241,053	70,033	319,951
General health	2,098,867	58,016	18,467,680	4,291,841
Information and education	2,901,710	3,443,741	2,881,614	3,330,651
Laboratories	16,819,993	24,538,380	25,113,986	21,875,847
Licensure and improvement of standards	386,330	2,000,791	2,010,125	728,376
Local health services	93,636,395	100,893,292	59,428,761	134,554,672
Nursing	2,585,730	4,789,114	2,774,033	2,077,157
Nutrition	374,476	427,472	489,410	443,265
Training	597,275	4,664,442	1,694,035	2,509,364
Veterinary public health	54,943	59,056	91,800	65,569
Heart disease	4,353,801	4,245,521	2,989,498	2,810,172
Home health	2,620,090	1,895,775	1,041,031	1,427,405
Management services	22,472,200	29,824,280	21,284,888	20,707,867
Central administration	15,821,525	26,358,952	17,535,533	14,331,762
Program administration	3,366,696	0	692,961	2,453,503
Statistics	3,283,979	3,465,328	3,056,394	3,922,602
Subtotal	223,294,390	263,494,890	251,942,280	290,273,235
314(d) awarded	(55,563,359)	(54,001,694)	(75,397,460)	(75,504,143)
Mental health	87,337,066	93,912,586	182,800,750	218,527,771
314(d) awarded	(9,089,635)	(9,004,264)	(13,506,820)	(13,531,790)
Total	310,631,456	357,407,476	434,743,030	508,801,006

[1] This table includes the amounts initially budgeted in the State plans for public health services under sec. 314(d) of the Public Health Service Act submitted by the State health and mental health authorities and approved by the regional health directors. These figures do not reflect subsequent budget revisions nor the amounts finally expended for the designated health programs. They also do not reflect the amounts budgeted for the total State health and mental health agency's operations.

[2] Fiscal year 1968 amounts are revised to include information available in the community health service from State health departments of 54 State and Territories and from the State mental health authorities of 53 States and Territories.

[3] Fiscal year 1969 figures include information available in the community health service from State health departments of 56 States and Territories and from the State mental health authorities in 55 States and Territories.

[4] Fiscal year 1970 figures include information available in the community health service from State health departments of 55 States and Territories and from 56 State mental health authorities.

[5] Fiscal year 1971 figures include information available in the community health service from State health and mental health authorities in 56 States and Territories.

[6] From the information available, these program classifications could not be broken down into their program components.

[7] Included in the amount shown for communicable disease.

[8] Included in the amount shown for environmental health.

[9] Includes an unidentified amount of support for sanitary engineering programs.

Mr. ROGERS. Thank you.

Dr. ZAPP. Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Hume and Dr. Webster.

We welcome you to the committee. We appreciate your presence here today.

STATEMENTS OF DR. BRUCE P. WEBSTER, PRESIDENT, AMERICAN SOCIAL HEALTH ASSOCIATION, AND DR. JOHN C. HUME, CHAIRMAN, EXECUTIVE COMMITTEE

Dr. WEBSTER. I am Dr. Bruce Webster from New York. I am chairman, National Commission on Venereal Disease, professor of clinical medicine, Cornell University Medical College, and president, American Social Health Association.

I have a statement here which we have prepared which I would like to submit for the record (see p. 50).

In addition, I have the report of the National Commission on Venereal Disease appointed by the Assistant Secretary of HEW (see p. 107, this hearing), and "Today's VD Control Problem," published recently by the American Social Health Asociation (see p. 143, this hearing).

Mr. ROGERS. We will make these part of the record, Dr. Webster.

Dr. WEBSTER. As has been pointed out, gonorrhea is epidemic. The important factor is that 80 percent of the cases of venereal disease are being treated by practicing physicians. They are only reporting to the State health departments 10 or 12 percent of those. The National Commission felt it was very important that we bring into this picture the various elements of private medicine.

This Commission was appointed a year ago by the Assistant Secretary. It is composed of the American Medical Association, American Osteopathic Association, National Medical Association, and various public health groups concerned with the treatment of venereal disease. We have worked closely with NIH, CDC, NIMH and brought in many consultants. The report was submitted to Dr. DuVal recently. One of the important recommendations in this Commission's report had to do with research.

There is great scarcity of research in the venereal diseases. If a fraction of the work that had gone into polio had gone into venereal diseases, we would probably not be in the position we are in today. So we have urged the need for greater extramural research, that is research in the medical schools, and the schools of public health. The important problem at the moment is the gonococcus. We need a better diagnostic test. We need to know a great deal more about the organism. Vaccine has recently been developed for the meningococcus, which is closely related. It would seem possible that such a vaccine is possible for the gonococcus.

One of these new approaches has to do with prophylaxis. There is research going on at the moment at the University of Pittsburgh School of Public Health in prophylaxis, with new approaches. They have great trouble funding this. There is need for research in the behavioral sciences to know more about the high risk groups. Why are they in this position? How do we approach them?

We feel also there is need for research into present control methods. Why have they not succeeded in curbing this disease? The National

Commission has recommended that $6.5 million of earmarked money be available for extramural research for 1973, escalating to $19.5 million in fiscal 1977.

We dealt with education. I should like to say a word about the need for professional education. There has recently been in this country, a group sponsored by WHO of the leading venereal disease people from various countries in the world. They toured the United States and they have submitted a report which is not yet available, but which I have had access to. Our Commission met with them. They pointed out something that we are aware of, there is a great shortage of medical manpower interested in handling these diseases in the United States.

The reason has to do with the fact that there has been no teaching of venereal disease control, virtually, in the medical schools for the last 20 years.

I did a study a number of years ago for the World Health Organization. This is true all around the world. Accordingly, the Commission has recommended that teaching and training grants be made available to the medical schools and the schools of public health in an effort to stimulate this undergraduate teaching. Unless you interest the medical undergraduate, you are going to lose him as far as interest in this disease is concerned. Accordingly, we have recommended earmarked money for teaching and training grants.

We have also urged that the VD clinics be put back into the university and community hospital. Since the practicing physicians are treating a great majority of these cases, we feel that some of the work ought to be based in community hospitals. Of course, again, as Dr. Sencer has said, there is great need for increased project grants to States for increased screening in order to diagnose gonorrhea, and money to improve the status of the venereal disease clinics.

Again, they need funds for the cooperative relationship between the practicing physician and State and city health departments. It seems apparent to the Commission that the present methods have not controlled venereal disease and therefore we must put our hopes in new approaches. This is why we feel that the question of financing these various projects is very important.

Dr. Hume will say more in regard to this.

(Dr. Webster's prepared statement follows:)

STATEMENT OF BRUCE WEBSTER, M.D., CHAIRMAN, NATIONAL COMMISSION ON VENEREAL DISEASE, CLINICAL PROFESSOR OF MEDICINE, CORNELL UNIVERSITY MEDICAL COLLEGE, AND PRESIDENT, AMERICAN SOCIAL HEALTH ASSOCIATION

It has been estimated that there were 2½ million cases of gonorrhea in the United States during the past year. In addition to this, there were probably 100,000 cases of infectious syphilis. Why is this happening? We know the etiological factor for both of these diseases and we have potent therapeutic agents with which to treat them. Further, a few years ago, we apparently had these diseases almost under control, with rapidly declining rates. Many factors play a role in what has happened. Important among these is the fact that a recent survey showed that 80% of the cases of venereal disease in this country were treated by private practicing physicians and that of these, they reported only approximately 10%. It is thus apparent that the practicing physician is a key factor in the control of these diseases. This is in sharp contrast to the situation 10 or 15 years ago when the majority of cases were treated in Federal or State controlled public clinics.

In 1969, the American Social Health Association, in conjunction with the American Medical Association and the Communicable Disease Center, brought together in Chicago representatives of the various professional organizations

concerned in the treatment of the venereal diseases. Out of this grew the concept of a National Commission comprised of representatives of public health and private medicine, to make recommendations for the control of the venereal diseases in the United States.

In 1969, a resolution was proposed at the General Assembly of the World Health Organization, recommending that National governments and nongovernmental bodies elect panels of experts to evaluate their venereal disease and treponematoses programs. Shortly after this, several such commissions or panels were appointed in European countries.

In February 1971, such a Commission was named in the U.S. by the Secretary of Health, Education and Welfare. Represented on this Commission were the majority of the various agencies of organized medicine and osteopathy concerned with the control of the venereal diseases. This included the American Medical Association, the American Osteopathic Association, the American Public Health Association, the American College of Physicians, the National Medical Association, the Department of Defense, the American Academy of Family Practice, the American Venereal Disease Association, the Association of American Medical Colleges, the American Social Health Association, the American Academy of Pediatrics, the American Urological Association, the American Academy Dermatology, the American College of Obstetricians and Gynecologists, and the American Academy of Neurology. The Commission included among others, Dr. Carl Hoffman, the president-elect of the American Medical Association, Dr. T. B. Turner, former Dean of the Johns Hopkins Medical School, Dr. John Hume, the Dean of the Johns Hopkins School of Public Health, and other distinguished physicians.

In addition, many distinguished consultants were called upon. The Commission worked closely with the Center for Disease Control in Atlanta. The work was further aided by a Traveling Seminar of World Health experts who toured the United States in the Autumn of 1971, and evaluated the venereal disease control program in this country. This study, by a group of impartial experts, was available to the Commission.

The Commission was charged with the following tasks:

1. To outline ways to improve among medical students and practicing physicians the knowledge of, clinical management of, and public responsibility for venereal diseases.
2. Devise ways to increase the understanding among private physicians of the venereal disease problem and to bring public health and private medicine into a closer working relationship.
3. Identify broad and specific areas of VD research needs.
4. Make recommendations for implementing a program designed to reduce the incidence of venereal disease.

At the initial meeting of the Commission, five subcommittees were appointed on the following subjects:

1. Research
2. Education
3. Private medicine and public health
4. Operational research
5. Implementation

Realizing the emergency nature of the situation, the Commission recommended that known control techniques, including case finding and public education, be fully employed on a nationwide basis while newer methods are being developed and implemented, and that such programs be funded primarily through Federal project grants.

The final report of this Commission was presented to the Assistant Secretary for Health and Scientific Affairs of the Department of Health Education and Welfare on April 4, 1972.

EDUCATION

The Commission considered the question of Education both from a professional viewpoint and from the point of view of the general public.

Professional

Many of us have been aware, for some time, that there is little or no instruction concerning the venereal diseases being carried on in the medical schools in this country. This has been substantiated by a WHO study and by the findings of the recent WHO Traveling Seminar. As a result of this, young doctors are leaving our medical schools with very little interest in, or knowledge of, the venereal diseases. Further, a generation of practicing physicians has gone out of

these schools under the same circumstances. Accordingly, the Commission has recommended that a teaching grant, in the range of twenty to thirty thousand dollars per year be made available to medical schools and schools of public health in the United States, in an effort to stimulate such education.

This shortage of medical manpower to combat the venereal disease problem was emphasized by the World Health Traveling Seminar referred to previously. In an effort to meet this manpower shortage, the Commission recommended that $4,200,000 be made available and earmarked in 1973 for project grants for VD training programs in professional schools and associated traineeships. It was recommended that this be escalated to $5,235,000 in 1977.

Public

The Commission recommended that education concerning the venereal diseases be introduced in the curriculum of public, parochial and private schools no later than the seventh grade.

The Commission concerned itself with the question of public education. It recommended that the Federal government initiate and support a program of public education and information similar to that carried on by the National Consumer Clearinghouse on Smoking and Health. It should include information concerning signs and symptoms, prophylaxis, prevention, and facilities for treatment and should be geared to the various consumer groups concerned. There is strong evidence that our approach to public education in the past has been too indirect, too scattered, and to some extent, unacceptable to the groups toward which it was directed.

The Commission has recommended that $2,200,000 be available and earmarked for this program in 1973 and expanded to $2,775,000 in 1977.

RESEARCH

Under the leadership of Dr. T. B. Turner, former Dean of Johns Hopkins Medical School, the subcommittee on Research outlined the Commission recommendations in this field. It was recognized from the beginning that through the lack of funding and lack of interest, only minimal amounts of research in the basic aspects of syphilis and gonorrhea were being carried out in the United States. Only a handful of workers were engaged in investigation of the nature of the causitive organisms of these two diseases. The recent breakthrough of a vaccine for the meningococcus gives stimulus and hope that such a possibility is available for the gonococcus. The Commission has held meetings with members of the staff of the National Institute of Health and valuable assistance was rendered to the Commission by them. Close collaboration between this institute and the Center for Disease Control is a necessity. In general, the Commission has urged that research, both inside and outside the Department of Health, Education and Welfare be instigated with a view to increasing our basic knowledge of the microbiology and immunology of the gonococcus ano the treponema pallidum, which causes syphilis. It was felt that this research should be directed toward better diagnostic methods for gonorrhea, the effectiveness of prophylaxis of these diseases and ultimately, the possibility of a vaccine for syphilis and gonorrhea.

It was further recommended that research into the effectiveness of current control programs be undertaken. Other countries appear to have achieved good results in VD control with less emphasis on the epidemiological approach and greater emphasis on education and clinical management. Contact was made with the National Institute of Mental Health with the idea of promoting studies in the behavioral sciences as a method of control of the venereal diseases. We know too little about the behavioral motivations of the high incidence groups or their attitudes toward present methods of control or prophylaxis.

The Commission recommended that a total of $6,500,000 be available and designated in fiscal 1973 for intra and extramural research in the venereal diseases, and that this be escalated to $19,500,000 in fiscal 1977.

To reach the practicing physician the Commission recommended that medical specialty groups including the American Medical Association, the American Osteopathic Association, the American Academy of Family Practice and the various specialty groups concerned establish standing committees on the venereal diseases, with mechanisms for communication among and joint action by these committees. Two such committees have already been appointed by Commission members in anticipation of this report.

It was further recommended that each state and where appropriate local governments, establish permanent commissions or similar advisory groups with

representation from medical and other professional health groups, legislative bodies and the general public to advise responsible health officials on their venereal disease control program. In this way, it was hoped to reach the practicing physician and promote a better understanding of the epidemiological control of the venereal diseases.

In the light of the extensive communication between both HEW and the component groups themselves which has resulted from meetings of the National Commission, it is strongly recommended that an Advisory Council on Venereal Disease with appropriate governmental and nongovernmental membership be established to make recommendations to the Assistant Secretary for Health and Scientific Affairs of the Department of Health, Education and Welfare, for the implementation of the research and control programs designed to reduce the incidence of the venereal diseases.

And finally, the Commission strongly recommends that appropriations and expenditures for the venereal disease control activities of the Department of HEW be substantially increased. While all elements of the program require augmented appropriation, it is recommended that significantly higher proportions be allocated to public and professional education and research than has previously been the case. In strengthening the operational control program, State and local governments should be persuaded to assume financial responsibility for an increasingly large proportion of the total effort.

For the implementation and management of a nationwide venereal disease control program for project grants to States and the VD Branch operating funds, the Commission recommended a Department of Health, Education and Welfare funding of $35,450,000 in fiscal 1973, escalating to $43,300,000 in 1977.

In summary, the Commission recommends that total Federal funding for the venereal disease branch operations, for project grants to states, for venereal disease research, and for the implementation of a venereal disease professional and nonprofessional education program, in the amount of $46,150,000 be appropriated and allocated and obligated for fiscal year 1973 increasing to $68,035,000 for fiscal year 1977.

CONCLUDING OBSERVATIONS

Our concluding observations with reference to HR 14455 are:

1. Passage of the Rogers Mill, HR 14455, amending section 317 of the Public Health Service Act, titled Grants For Vaccination Programs And Other Communicable Disease Programs, is essential to the control of communicable diseases generally, assuring greater flexibility to deal with them, greater involvement of the private nonprofit organizations, and more nearly adequate financing support levels.

2. Passage of an even more specifically earmarked National Venereal Disease Prevention and Control Act, such as HR 14455, is additionally essential to control the venereal diseases—because they have complex roots in human behavior, and they are increasing rapidly in epidemic proportions; and *because failure of past control measures to do the job demands development of new, additional techniques and programs.*

3. The proportionate emphases among the major elements of a nationwide venereal disease program, and financial support levels for them, should be revised to coincide with the expert recommendations from both the private and government medical sectors, which were recently released. In definition and full support of these recent recommendations, we submit to this Committee the following: the 7-page statement abstracting the Report of the National Commission on Venereal Disease, which precedes these "concluding observations," already provided in 75 copies; the complete Report of the National Commission on Venereal Disease provided today in a single manuscript copy; and Today's VD Control Problem 1972, provided today in a single copy, but recently mailed to each member of the Senate and House, by the American Social Health Association.

Mr. ROGERS. Thank you.

May I just ask one question: What is the amount of the research going into the vaccine research project?

Dr. WEBSTER. There is very little at the present time. There are three or four small projects, some of them funded through CDC, some of them funded by foundations.

Really, to the best of my knowledge, there are only two small projects, three at most, going on in this country so far as the vaccine for

syphilis is concerned. There is a limited amount of fundamental work going on in gonococcus.

Mr. ROGERS. Could you let us have something for the record on this? I think the committee would be interested in seeing if we can increase some support in this area. I think it is very important.

Dr. WEBSTER. We will be glad to.

Mr. ROGERS. Thank you.

(The following letter was received for the record:)

NATIONAL COMMISSION ON VENEREAL DISEASE,
New York, N.Y., May 3, 1972.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

MY DEAR MR. ROGERS: In accordance with the request which you make on April 27 when I attended your hearing, I have obtained the following information in regard to the amounts of federal money expended on venereal disease research.

The Center for Disease Control tells me that they had $250,000 during the last fiscal year available for venereal disease research that the National Institute of Health had $500,000 available. In addition to this, there are probably small amounts of money not more than $100,000 provided by private foundations and the World Health Organization.

In the report of the National Commission, a subcommittee headed by Dr. Thomas Turner, the former Dean of John Hopkins Medical School, recommended $6,500,000 for venereal disease research for fiscal 1973 escalating to $19,500,000 for fiscal 1977.

It appears to some members of the Commission that two of the most pressing long-term approaches for the control of the venereal diseases are:

1. Increased fundamental research in an effort to obtain new approaches
2. Professional education and training programs to reintroduce this subject into our medical schools and obtain a hard corps of physicians with knowledge of and interest in the venereal diseases.

It further appears to members of the Commission that these two factors seem to be getting less attention than any of the other recommendations. We strongly urge that earmarked money for these two projects be made available.

Please do not hesitate to call on me at any time if I can be of any further assistance.

Sincerely yours,

BRUCE WEBSTER, M.D.,
Chairman.

STATEMENT OF DR. JOHN C. HUME

Dr. HUME. I am Dr. John Hume from Baltimore, Maryland. I am Chairman, Executive Committee, American Social Health Association, a Member of the National Commission on Venereal Disease, and Dean, School of Hygiene and Public Health, The Johns Hopkins University.

I will try not to duplicate what Dr. Webster has said. We are speaking in support of the bill which you have introduced, H.R. 14455. We, I think, differ from the previous witnesses in that we feel that it is very unlikely that through the more general approaches under 314(d) and (e), adequate human and fiscal resources can be mustered to mount a truly successful and truly national venereal disease control program. We think that the $50 million that would be authorized under this bill is quite adequate for the purpose of aid to State programs. We are particularly impressed by the need not only for earmarking but that there be a definite application and plan submitted.

Not only that, but that there be progress reports on what has been done during the previous years, otherwise we think it is hard to hold individuals and organizations responsible. We would of course prefer to see the bulk of these grants to States for VD go to them

under a formula, based on the size of the problem of the State, their financial need and to a lesser extent perhaps on population.

We also would like to see a requirement that these funds be used to supplement and not replace State and local funds which are now going into these programs and which are estimated to be about two-thirds of the funds that are used in VD control.

I would like to say that while this bill addresses itself to a very important element of the program, we feel it addresses itself only to the short term part of the solution. In other words, I think there is no question that we have the tools available to use to make great inroads in the control of the diseases. On the other hand, historically not only in venereal diseases but in all of the communicable diseases it is plain to see that when a disease becomes a serious problem we mount a vigorous program, we solve the problem, then support for it diminishes, public apathy sets in, and the first thing you know we are off on another turn of the cycle where we are losing ground rather than gaining ground.

It is for these reasons that we feel that either as a part of this legislation, or through other devices, adequate funds be set aside for the support of research, specifically in the venereal diseases.

Again, we find a situation where there are funds available in theory but in actuality they are not used. We do not believe that under present circumstances there will be really many applications for support of research in VD, perhaps because it will require people to transfer their field of interest. In other words, a man who is now working in one field, getting money for that, is less apt to be persuaded to switch his interest unless there are earmarked funds, even in the research field.

Dr. Webster has referred to professional education. We feel that that is a basic element, again either under this legislation or through some other, and we are not going to make the progress we should, either for the short or long term, unless we do get greater support for professional education.

Now, the Commission in setting forth its needs of course did not know what bills were going to be introduced and did not really feel it was up to them to say how the Congress in its wisdom should make these funds available. But we did feel that for 1973, project grants to States at the level of at least $25 million should be available; that there should be funds for the activities of the venereal disease branch including the functions of the venereal disease research laboratory and public education, and for these purposes there should be $1045 million in that same year.

We also recommend $4.2 million for professional education and $6.5 million for venereal disease research, or a total of $46 million for fiscal year 73. We did escalate this, however, so that by 1977 the amounts would be $30 million for grants; $13.3 million for the operational funds and the activities of the Department of Health, Education, and Welfare; $5.2 million for professional education, and $19.5 million for VD research for a total of $68 million.

Now, that information is in the commission report which you have. It is backed up with explanations of how we arrived at these figures.

I will not take more of your time now.

Mr. Rogers. Thank you very much. Your testimony has been most helpful.

Dr. Carter?

Mr. CARTER. Thank you, sir.

I am glad to hear the very distinguished gentlemen and members of the public health profession. I think what they say is quite right. For myself, I believe I would like to implement their proposals so far as we can.

I noticed one interesting statement that was made; that is, the development of the meningococcus vaccine. That offers great hope to the people of this country. I am in hopes that plan can be carried out and we can have a program of immunization throughout our country. Preventive medicine means a lot. I just hope that we can reach a dedication in this field which we seem to have lost over the past few years. I don't know that our public health officials throughout our country are working on their jobs as well as they did.

When Dr. Arthur McCormick was the health commissioner of our State he had a very lively organization which did lots of work. I think we in the future should have the dedication to accomplish these jobs. Thank you.

Mr. ROGERS. Thank you.

I share the concern to see if we cannot do something about research in particular.

Mr. Preyer.

Mr. PREYER. I have no questions.

I particularly like your point about the cyclical nature of our attack on these things. We go at polio, measles, and so forth, and then we backslide. I hope we can mount a sustained attack instead of the bits and starts approach that we have been using.

Thank you very much.

Mr. ROGERS. Thank you for your presence.

Dr. HUME. These figures that we have put down here are based on the assumption that the funds will not only be authorized but they will be appropriated, allocated, and spent.

Mr. ROGERS. I wish we could give you all of those assurances. We can only go to authorization. But we can help.

Thank you so much for your presence here today.

Dr. HUME. Thank you.

Mr. ROGERS. Dr. Robert Parrott, American Academy of Pediatrics, Children's Hospital, Washington, D.C., and Dr. David H. Carver, Department of Pediatrics, Johns Hopkins University School of Medicine.

Dr. Carver, do you want to come up here, too? We will try to get to you because we have another quorum call.

We will make your statements a part of our record in their entirety, and if you will, highlight for us the specifics that you think the committee should really emphasize.

Dr. Parrott.

STATEMENT OF DR. ROBERT H. PARROTT, MEMBER, COMMITTEE ON INFECTIOUS DISEASES, AMERICAN ACADEMY OF PEDIATRICS

Dr. PARROTT. Mr. Chairman, for the American Academy of Pediatrics, I will point out, first, that the academy is one the major movers for preventive medicine. Much of pediatrics is a method of preventive medicine.

The academy supported the original Vaccination Assistance Act, and is vitally interested in the bill such as the one you propose, primarily because it will highlight the problem; it will highlight the problem of the need for immunization against these diseases.

We know what we can do. It is a matter of going out and doing it. We are concerned with respect to the diseases that can be prevented by immunization. We are concerned, largely, with support, earmarked support, with added programs of public education, professional education, and outreach.

Outreach to, particularly, the inner-city groups that are not getting vaccinated or rural groups, as well. We would know one thing in the bill as you propose it.

It is not clear, and we would urge that you look at this more closely. It is not clear there is to be support for public education or outreach efforts. Now, it may well be that that is the intent, but we would strongly suggest that that be part of it.

I make the same general point with regard to identification, prevention, and treatment of venereal diseases. Probably, before we can really move ahead in this, we have to have our country realize that, as the statement says, venereal disease is up and down the street from everyone of us.

It is not just where a lot of people think it is, in the ghetto and in the cities. It is all over the place. It is in every social strata.

Public education is necessary here, perhaps, to help you get support for appropriations behind these authorizations, but, as well, to enable programs that are mounted to work.

That is the gist of our feeling. We urge support of this bill.

(Dr. Parrott's prepared statement follows:)

STATEMENT OF DR. ROBERT H. PARROTT FOR THE AMERICAN ACADEMY OF PEDIATRICS

My name is Robert H. Parrott. I am a pediatrician, a member of the Committee on Infectious Diseases of the American Academy of Pediatrics and I am also Director of Children's Hospital of the District of Columbia and Chairman of the Department of Child Health and Development, George Washington University Medical Center.

For the American Academy of Pediatrics and for myself I am here to support the provisions and concepts of HR 14455 which would resurrect support for distinct authority and mandate to the Department of Health, Education and Welfare to eradicate those communicable diseases for which the tools of eradication exist. The Academy supported the original Communicable Disease Control Act of 1962 and believes that specific authority and funding should be continued for these purposes in a continuous way.

Why are we concerned? Why a distinct authority on special funding?

Our concern and frustration are that we know medically what can be done in the instance of diphtheria, tetanus and whooping cough as well as poliomyelitis, measles, and rubella. We know that immunization will work. Under the impetus of the earlier Vaccination Assistance Acts we have attained increased levels of protection against diphtheria, tetanus and pertussis over those ever attained before. We have virtually wiped out poliomyelitis. We began a masive reduction in measles incidence including reduction in fatal encephalitis. We turned the tide of rubella infection with a resultant reduction in the horrible fetal wastage and anomalies that result from maternal rubella infection. But more needs to be done and we cannot relax. In the case of all of the above mentioned diseases there is reason for concern that immunization levels are dropping, particularly among our less informed and helpless families, usually in our major cities. With the information and tools at hand we should not have even one case of measles encephalitis or one damaged heart as a result of rubella. Consider in the case of measles the estimates of Finkel for what was accomplished with immunization between 1963 and 1968: 9.7 million cases of measles were

averted, 3,000 cases of mental retardation were prevented, 973 lives saved, 555,000 days of hospitalization were avoided and 32,000,000 days of absence from school averted. It is estimated that this was worth $423,000,000. Continued strong support is needed. We need more funds for vaccination assistance and information programs and particularly for outreach efforts to find pockets of unprotected children and protect them. Without a distinct authority directed to these problems the chance exists that they will become lost in the massive HEW haystack. Funds, in fact, have been reduced under previous authority. We ask renewed special attention to immunization programs and fuller funding for these programs.

We also direct our concern specifically at the need for the designation of similar authority in HR 14455 to awaken our country, its citizens and its medical establishment to the fact that gonorrhea and syphilis, those hush-hush diseases of the past, are present in epidemic proportions. We must and can mobilize our collective resources to eliminate these diseases before they become the plague of the 70's.

The facts are indeed frightening. It is estimated that there will be 600,000 reported cases of gonorrhea in one year and it is well known that only a limited number of cases are reported. How is it that such an epidemic could have taken hold in our country? Perhaps the problem is in part that we cannot as a nation of puritan heritage accept the idea that even our very young children could possibly have these "social diseases." Perhaps we cannot stomach the fact that this epidemic of diseases thought by most to be a thing of the ghetto is broadcast through every social and economic stratum in our country. We must take our heads out of the sand. A massive public-private effort is needed such as could be launched with the help of a special HEW authority and mandate in HR 14455.

We must:

1. Open our eyes to the fact that gonorrhea and syphilis exist up and down the street from each of us.

2. Open our minds next to the need for much fuller sex and health care education for youngsters but also for all of us. Like it or not, the age of reproductive sex activity has become lower and the mores of society more free.

If this is so at least the preventable and treatable consequences must be made known to the public and then prevented and/or detected and treated.

Because the problem is so broadcast and because both our general attitudes and knowledge are so limited, a public authority is needed. This can spur and finance a public-private effort to stem the tide.

In brief, then, we ask your support for extension and broadening of the Communicable Diseases Control Amendments Act with special funding authority to permit a broad scale attack on communicable diseases in our country.

ADDENDUM TO STATEMENT

Prevention is the cornerstone of pediatrics, and health education of children, adolescents and parents is an integral part of pediatric practice. Within the past two years the American Academy of Pediatrics has embarked upon a national public education program utilizing the television media. Seven public service television spots have been developed to communicate with parents regarding the value of preventive medicine, immunizations, and proper health care. Five of these public service announcements dealt specifically with infectious diseases, two spots dealt with polio, one was devoted to measles, one discussed rubella and the fifth in this category discussed the procedure and value in tuberculin testing.

These materials have ben distributed to approximately 500 television stations throughout the United States. On a postal card followup survey to determine the feasibility of the Academy's efforts in this area, we have been encouraged by the positive response. Approximately half of the television stations responded to our survey, 240 of whom had indicated they were using the materials. Many programs pointed out that these public service announcements were particularly useful for broadcasting during a period when community immunization programs were being conducted. The apparent success with which this effect has been met has encouraged us to expand our program and currently we are developing further materials on communicable disease control and also expanding into the area of nutrition education.

The Academy's efforts are but one example of the types of programs which could be mounted so that more attention might be paid to preventing disease and illness rather than treating it. Unfortunately, however, the bill before us provides no authorization of funds for public education programs in conjunction with

communicable disease control. Surely the value of educating parents about the need for and availability of immunizations and other preventive care programs is self evident. The Academy, therefore, urges that the bill be amended to include an authorization of appropriations for the specific purpose of developing and implementing public education programs in the area of communicable disease prevention and control.

Mr. ROGERS. That is very helpful. Let me ask you this: Do you think we should have a requirement in the law, perhaps subject to a civil penalty, on reporting communicable diseases?

Dr. PARROTT. I think that it is a matter of education, too.

Mr. ROGERS. You know we can't educate, we don't have time to educate everybody. I don't think any doctor would object if we just say we want all recognizable cases of communicable diseases reported to public health doctors.

Dr. PARROTT. The States already say that.

Mr. ROGERS. Some of them do, some don't.

Dr. PARROTT. Most of them do. The people don't do it. My point is why don't doctors do it? They don't do it because they are ornery. They don't do it because they have not seen that system work. It has also been cumbersome. There should be a simpler way of reporting, hotline kind of reporting, which makes it easy for them to do.

Mr. ROGERS. Just say you can call in and report it. They dial a number and say "What doctor reported it?"

Dr. PARROTT. Further, traditionally, and in too many areas, there is no followup. You report it, so what?

Mr. ROGERS. Well, we'll see if we can't get some action. That is a good suggestion.

Doctor, thank you very much. Are there any questions on it?

We appreciate your presence today.

We shall now here from Dr. Carver, Department of Pediatrics, Johns Hopkins University.

STATEMENT OF DR. DAVID H. CARVER, DIRECTOR, DIVISION OF INFECTIOUS DISEASES, DEPARTMENT OF PEDIATRICS, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

Dr. CARVER. As director of the Division of Infectious Diseases of the Department of Pediatrics at Johns Hopkins University School of Medicine, I think that the provisions of the bill are needed for optimal health care of the pediatric population.

The bill specifically provides funds for control of measles, poliomyelitis, diphtheria, tetanus, and whooping cough. Effective vaccines are now available for all of these diseases. However, they are not currently given to all the pediatric population at risk.

The data in the accompanying tables from morbidity and mortality weekly reports indicates that the annual number of cases of measles in the United States first dropped from 482,000 in 1962 prior to licensing of measles vaccine to 204,136 in 1966 at the start of the Federal measles eradication program and then reached a low of 22,231 cases in 1968. The 1971 rise to 75,007 cases is of concern and appears related to the decline in the use of measles vaccine as noted in the accompanying report published in the "Journal of Infectious Diseases." This report also gives data indicating that (1) measles vaccine is effective in protecting against the disease; (2) the disease occurs disproportionate-

ly among the lower socioeconomic classes; and (3) the disease occurs disproportionately among black persons. The last two groups are those least likely to receive vaccine. This data is in agreement with our local findings in Baltimore where during February and March 1970, 130 indigent children were seen with measles at the Johns Hopkins Hospital. Suburban practitioners did not find measles among their patients who were well immunized against this disease. A survey of indigent inner city children seen in one Baltimore clinic indicated that only 58 percent were immunized against measles.

The decline in the incidence of paralytic poliomyelitis indicated in the enclosed graph from neurotropic disease surveillance 1970 shows the efficacy of the polio virus vaccines which were used extensively during the period covered. It can be seen that 55,000 cases occurred in 1959 and only 32 cases occurred in 1970 (mainly in Texas). Pediatrics (April 1972) indicates that 97 percent of the Texas cases were inadequately immunized.

An interesting paper was published yesterday in the Journal of Pediatrics, April 1972. It indicated that 97 percent of the Texas cases were inadequately immunized, and that these were indigent patients of Latin American background.

The DPT vaccine against diphtheria, tetanus, and pertussis, has been used extensively and has been shown to be very effective. Those cases noted in the accompanying tables from morbidity and mortality weekly reports occurred in unimmunized children with the exception of some cases diagnosed as pertussis but really due to adenoviruses.

All subsequent data except where otherwise indicated comes from morbidity and mortality weekly reports (MMWR).

As can be seen in the accompanying tables from the December 4, 1971, issue of MMWR in 1971, 78 percent of the 1- to 4-year-old population of the United States had three doses of DPT vaccine (against diphtheria, tetanus, and pertussis), 67 percent had received poliovaccine, and 61 percent of this population had received measles vaccine. The figures given for the same age group in poverty areas indicate that only 58 percent had received DPT vaccine, only 54 percent had received poliovaccine and only 48 percent had received measles vaccine. Thus the indigent are markedly less protected against several diseases which can have serious sequelae and also result in the death of infected patients.

Rubella (German measles) is mainly of concern with respect to the serious teratogenic anomalies that occur in fetuses of mothers infected during pregnancy. These include mental retardation, heart disease, cataracts, deafness, and other abnormalities. Currently a number of different vaccines are being used in an attempt at wiping out this disease. Funds are definitely needed for studies which will determine the most effective rubella vaccine and the optimal time for vaccination.

Specifically included in this bill are other diseases which occur disproportionately but not exclusively among the indigent population. Venereal disease is notoriously under reported. However, the official figures still show 91,000 cases of syphilis and 600,000 cases of gonorrhea occurring in the United States in 1970. Funds are needed not only for treatment but also examination of contacts, general case finding, and education.

In 1970, 30,000 active cases of tuberculosis were reported in the United States. Here again, money is needed both for treatment and sur-

veillance so that patients can be treated before they develop serious complications such as meningitis.

The one other problem specifically discussed in the bill is Rh disease whereby a mother sensitized to the Rh antigen makes antibody which destroys the red blood cells of her child both before and after delivery. There is now available a preparation (Rh_0(D) Immune globulin) which can prevent sensitization of the mother when given following the birth of the first child and each subsequent child.

The best unofficial estimate available to me is that only 75 percent of the women who should receive this preparation are currently receiving it. Again a disproportionately small number of indigent patients receive protection afforded by this preparation. Prevention of sensitization is important since it is estimated that over 20,000 infants are born each year with defects due to Rh sensitization of the mother. Permanent brain damage is one of the defects that can occur. Also 5,000 pregnancies are estimated to end in stillbirth each year because of this disease. Thus it appears that funds are particularly needed to bring this new preventive to the indigent who are not currently receiving it.

Not included in the bill are two areas of communicable disease control which might be considered. The first is to make available passive immunization by giving short-term antibody to attenuate-specific diseases in exposed individuals.

Regular gamma globulin will attenuate the course of infectious hepatitus when given to family contacts of cases. By making this available through the Federal Government this could be used more widely and appropriately than currently occurs. Current research indicates that special gamma globulin with high titer of antibody against serum hepatitis is effective in attenuating this disease. A Federal program for the development and subsequent use of this preparation would appear appropriate. Sixty-eight thousand cases of hepatitis occured in the United States in 1971.

Certain individuals such as patients with malignancies are at high risk of dying when they develop chickenpox. There is now available in limited quantities preparations of antibody against chickenpox which can be used when such high risk patients are exposed to the disease. Again a Federal program for the preparation of specific hyperimmune globulin and subsequent utilization of the material appears appropriate for the current bill.

Finally, as a pediatrician it appears appropriate to me that funds be made available for the surveillance of the occurrence of specific diseases among pregnant woman. These diseases are those which have been shown to cause abnormalities in fetuses. Cytomegalic inclusion disease, toxoplasmosis and herpes infections would all be studied during pregnancies in addition to rubella. All of these can lead to severe brain damage in the affected child. Prospective studies would enable the determination of the true incidence of these diseases among pregnant women and also determine the percentage of fetuses born to women who have acquired each of these diseases who develop abnormalities. Some work is currently going on in these areas but more work is needed.

The question may arise as to why Federal funds should be targeted for this work rather than giving general funding to the States. Un-

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less the funds are targeted then a unified approach at nationwide prevention of these diseases will be lost with some of the States not attacking these problems. The recent availability of some Federal funds for measles immunization probably accounts for the rise in measles immunization among the indigent noted in the accompanying tables.

Another question may arise concerning whether child and youth (C and Y) projects may provide vaccines and other services in the bill. However, it must be emphasized that many of the indigent children do not live in census tracts served by these C and Y projects. Another problem is the particular need for vigorous new efforts in motivating poverty groups to immunize their children.

(Data and accompanying tables referred to follow:)

Morbidity and mortality weekly report—Annual number of cases

Measles:		Diphtheria:	
1971	75,007	1971	202
1970	47,351	1970	435
1969	25,826	1969	241
1968	22,231	1968	260
1967	62,705	1967	219
1966	204,136	1966	209
1965	262,000	1965	164
1964	458,000	1964	293
1963	385,000		
1962	482,000		

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NEWS

From the Center for Disease Control

Current Status of Measles in the United States

Live, attenuated measles-virus vaccine was licensed in the United States in March 1963. Widespread use after that time of measles vaccines caused the annual number of reported cases to decrease from almost 500,000 in 1962 to 22,231 in 1968 (figure 1). In the same years, the number of reported deaths and complications due to measles also decreased markedly. By 1968, it was anticipated that measles might soon be eradicated in the United States [1].

Since 1968, however, measles has been resurgent. In each of the last three years the number of reported cases has been higher than in the year before (figure 2), and at least 80,000 cases can be expected to occur in 1971.

Epidemiologic patterns. Measles, a disease usually transmitted by the respiratory route, has its peak incidence in the late winter and spring. In the current epidemiologic year[1] (EY 1970–1971), the number of measles cases began to increase in October and November after the usual low in the late summer. Then in February, the number of cases reported rose sharply and reached a peak in the last week of April. The number of cases reported in the peak period was the largest in any four-week period since 1966 (figure 2). Since April there has been a spontaneous decline.

Nearly all regions of the United States reported a resurgence of measles. The greatest number of cases occurred in the eastern and north-central states. Only 13 states to date have reported fewer cases in this epidemiologic year than at the same point in EY 1969–1970.

Measles occurred about equally in males and females. The great majority of cases were in children less than 15 years old. However, the median age of patients was significantly lower in urban outbreaks than in suburban and rural epidemics. In eight epidemics in cities the median age was

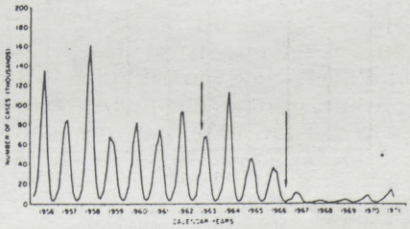

Figure 1. Reported cases of measles by four-week periods United States, 1956 through July 17, 1971. Arrows show licensing of vaccine in March, 1963 and initiation of eradication program in October, 1966.

no more than five years, while in six of seven suburban and rural outbreaks the median age of patients was at least six years (table 1). We suspect that the lower median age of urban patients reflects the fact that children in cities tend to mingle at an earlier age (in nurseries and in day-care centers) than do children in the suburbs and countryside.

Racial data, where available, suggest that a disproportionately large number of cases occur among blacks. In outbreaks of measles in Los Angeles, Dallas, Houston, and Little Rock, the percentage of reported cases in blacks was 2.5–4.5 times higher than the percentage of blacks in the population (table 2).

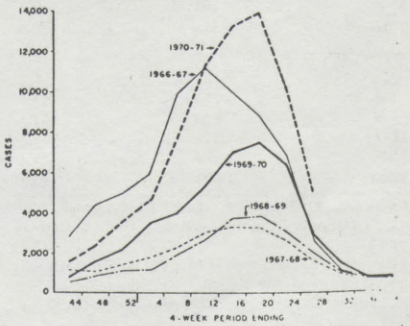

Figure 2. Reported cases of measles by four-week periods, United States. Epidemiologic year 1970–1971 compared with 1966–1967, 1967–1968, 1968–1969, and 1969–1970.

[1] The measles epidemiologic year (EY) begins with the calendar week 41 and ends with week 40 of the following year.

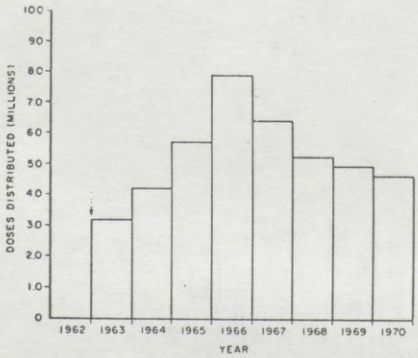

Figure 3. Distribution of live measles-virus vaccine, by year, United States, from licensing of vaccine in 1963 through 1970.

Very limited socioeconomic data suggest also that an undue proportion of cases occurs among children in the lower and lower-middle socioeconomic strata (table 3).

Use of vaccine. Distribution of measles vaccines in the United States has declined steadily since 1966. The CDC's Biologics Surveillance shows that total purchases of measles vaccines in 1970 were 42% lower than in 1966 (figure 3).

Table 1. Age distribution of patients with measles in recent outbreaks in the United States.

Age (years)	No. of patients	Percent of patients
Urban*		
<1	1,038	13.7
1–4	4,023	53.1
5–9	1,843	24.4
10–14	507	6.7
15+	162	2.1
Total	7,573	100.0
Suburban and rural†		
<1	109	6.8
1–4	280	17.6
5–9	970	61.1
10–14	211	13.3
15+	19	1.2
Total	1,589	100.0

* Chicago, Dallas, Little Rock, Los Angeles, New York, Oklahoma City, Texarkana, and Waterbury (Conn.).

† Aberdeen, S. Dak., Bowie Co., Texas, Campbell Co., Tenn., Greenwood and Round Lake, Ill., Jefferson Co., Ala., LeFlore Co., Miss., Opelika, Ala., Roane Co., Tenn.

Table 2. Percentage of measles cases in black persons in four cities or counties in the United States.

Locale	Population (1970 census)	No. of patients			% of blacks in population
		Total	Black	% Black	
Los Angeles Co.	7,032,075	172	49	28.4	10.8
Dallas Co.	1,327,321	972	494	50.8	16.6
Houston (Harris Co.)	1,741,912	219	120	55.0	20.2
Little Rock (Pulaski and Saline Co.)	323,296	265	246	89.0	18.9
Total	10,424,604	1,628	909	55.7	13.9

This decline in use of vaccine is the principal cause of the resurgence of measles. Also, the 1970 United States Immunization Survey showed that levels of measles vaccination in children have been falling since mid-1969. In 1969, 61.4% of all children one to four years old had received measles vaccine. By September 1970, the level had fallen to 57.2%, and levels were still lower in urban areas of poverty, where only 41.1% of one- to four-year-old children had received vaccine.

Recent epidemiologic studies have confirmed serologic studies [2, 3], which showed that live measles vaccines confer durable immunity against measles in most vaccinees. In 10 epidemics, live measles vaccines prevented clinical disease in well over 90% of recipients of vaccine (table 4). Only in relatively small groups of children who either received vaccine with immune globulin before age one [4, 5] or received vaccine improperly protected from heat and light, has efficacy of the vaccine been low [6].

Serious adverse reactions to live measles vac-

Table 3. Socioeconomic status of 172 patients with measles in Los Angeles County, California, May 1, 1970–December 31, 1970.

Socioeconomic group*	No. of patients	Percent
Lower	111	65
Lower-Middle	37	22
Upper-Middle	4	2
Upper	9	5
Unknown	11	6
Total	172	100

* Based on census-tract-income data.

Table 4. Measles attack rates by vaccination status and measles-vaccine efficacy in ten outbreaks of measles, 1969–1971.

Location	No. of cases	Attack rate (%) NV*	Attack rate (%) V†	Efficacy (%)
Aberdeen, S.D.	286	77.0	6.9	91.0
Bowie Co., Texas	606	10.5	0.4	96.2
Bremen, Indiana	20	43.9	3.6	92.1
Governor's Island, N.Y.	73	33.5	2.4	92.8
Greenwood, Ill.	44	45.0	3.6	92.0
Jefferson Co., Ala. [5]	37	27.8	4.2	84.8
Neshoba Co., Miss.	43	68.8	2.6	96.2
Northeastern Ohio [6]	17	52.4	5.4	90.0
Scott City, Kansas [7]	35	30.3	2.6	91.4
Waterbury, Conn.	106	60.5	2.0	97.4
Total	1,267			

* NV = not vaccinated.
† V = vaccinated.

cines have occurred infrequently. Between 1965 and 1971, 35.2 million doses of vaccine were distributed in the United States. During this period, CDC received 78 reports of complaints involving the central nervous system within 30 days of measles vaccination. Five of these cases were subsequently proved to have been due to other causes. Another 37 fulfilled the usual criteria for uncomplicated febrile convulsions [8]. In the remaining 36 cases, clinical pictures ranged from meningitis to encephalitis, myelitis, and peripheral neuritis. Seroconversion to measles immunity occurred in eight of these 36 cases, but virus was not isolated in any instance from nervous tissue or cerebrospinal fluid. Based on distribution of vaccine, the incidence of these episodes of central-nervous-system involvement within 30 days after measles vaccination was 1.02 per million doses of vaccine. This rate is certainly much lower than the incidence of encephalitis after natural measles. It is also less than the background rate for encephalitis due to unknown causes, which was shown in one study to be 2.8 cases/million children aged 1–9 years per 30-day period.[2]

The main concern now is to immunize more susceptible children against measles. Part of the need is money, and CDC has been allocated 6.2 million dollars for the purchase of additional supplies of measles (and polio) vaccines. In addition, new ways are needed to reach populations with low levels of immunity; CDC's Immunization Branch has recently established a section to deal with the problems of these groups. Higher levels of immunization should again curb the spread of measles.

PHILIP J. LANDRIGAN, M.D.
J. LYLE CONRAD, M.D.

[2] National Communicable Disease Center. Encephalitis surveillance, 1965 Annual Summary. U.S. Government Printing Office, Washington, D.C., 1 July 1966. 31 p.

References

1. Sencer, D. J., Dull, H. B., Langmuir, A. D. Epidemiologic basis for eradication of measles in 1967. Public Health Rep. 82:253–256, 1967.
2. Krugman, S. Present status of measles and rubella immunization in the United States: a medical progress report. J. Pediat. 78:1–16, 1971.
3. Lepow, M. L., Nankervis, G. A. Eight-year serologic evaluation of Edmonston live measles vaccine. J. Pediat. 75:407–411, 1969.
4. Baratta, R. O., Ginter, M. C., Price, M. A., Walker, J. W., Skinner, R. G., Prather, E. C., David, J. K. Measles (rubeola) in previously immunized children. Pediatrics 46:397–402, 1970.
5. Center for Disease Control. Epidemiologic notes and reports; measles–Alabama. Morbidity and Mortality Weekly Rep. 20 (13):115–116, 3 Apr 1971.
6. Lerman, S. J., Gold, E. Measles in children previously vaccinated against measles. J.A.M.A. 216:1311–1314, 1971.
7. Wyll, S. A., Witte, J. J. Measles in previously vaccinated children, an epidemiologic study. J.A.M.A. 216:1306–1310, 1971.
8. Livingston, S. Infantile febrile convulsions. Develop Med Child Neurol. 10:374–376, 1968.

From "NEUROTROPIC DISEASE SURVEILLANCE 1970 SUMMARY"

Figure 1 "BEST AVAILABLE PARALYTIC POLIOMYELITIS CASE COUNT," BY YEAR, UNITED STATES, 1958-1970

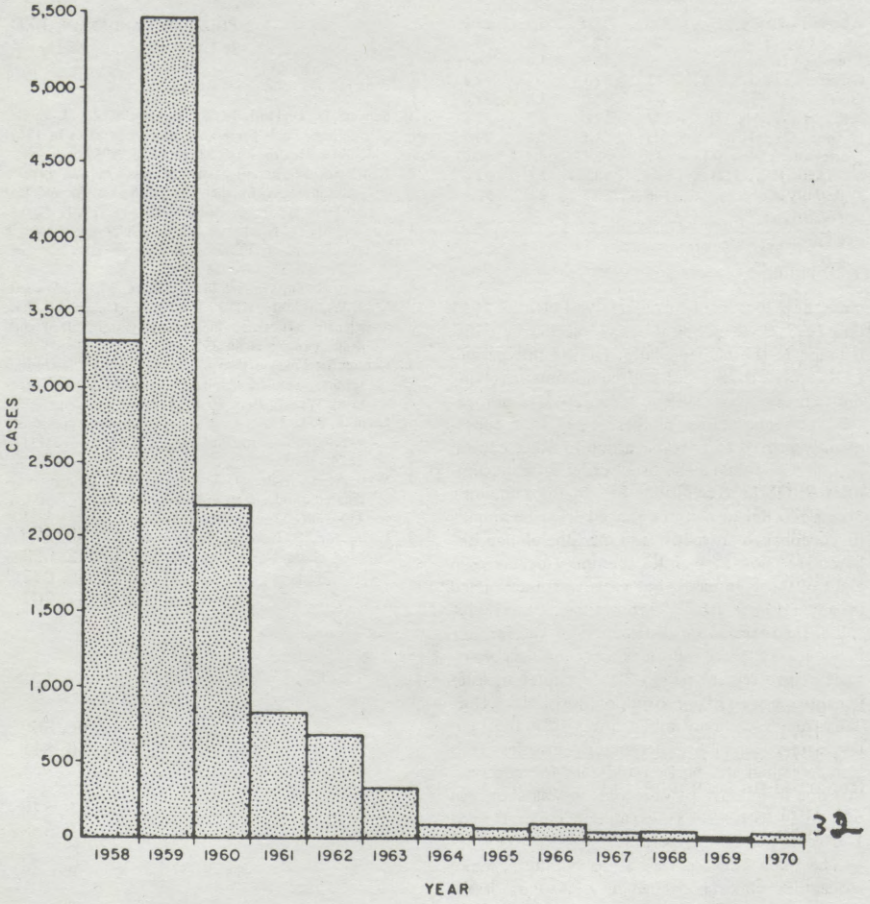

TABLE 1.—*Poliomyelitis cases reported to CDC in 1970*

A. Paralytic poliomyelitis cases with residual paralysis at 60 days	27
B. Paralytic polio cases without report on residual paralysis	4
C. Paralytic polio cases without residual paralysis	1
D. Aseptic meningitis due to poliovirus (nonparalytic polio)	0
Total	32

Venereal disease

Syphilis:	
1970	91, 382
1969	92, 162
1968	96, 271
1967	103, 581
1966	105, 159
Gonorrhea:	
1970	600, 072
1969	534, 872
1968	464, 543
1967	404, 836
1966	351, 738

Tuberculosis

New active reported cases:	
1970	37, 187
1969	39, 120
1968	42, 623
1967	45, 647
1966	47, 767

Hepatitis

Reported as infectious:	
1971	60, 368
1970	56, 841
Reported as serum:	
1971	8, 846
1970	7, 388

Morbidity and mortality weekly report—April 15, 1972

Tetanus:	
1971	120
1970	148
1969	185
1968	178
1967	263
1966	235
Pertussis:	
1970	4, 249
1969	3, 285
1968	4, 810
1967	9, 718

(Reported by the Immunization Branch, State and Community Services Division, CDC.)

Figure 1
DIPHTHERIA-TETANUS-PERTUSSIS IMMUNIZATION
1-4 YEAR AGE GROUP
UNITED STATES 1962-1971

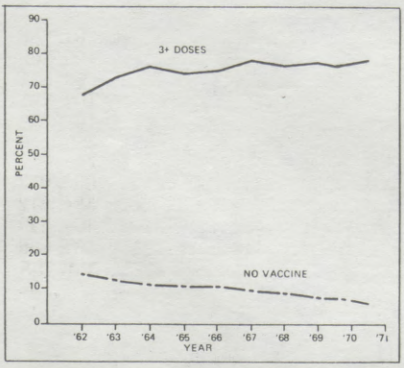

Figure 2
POLIO IMMUNIZATION, 1-4 YEAR AGE GROUP
UNITED STATES 1959-1971

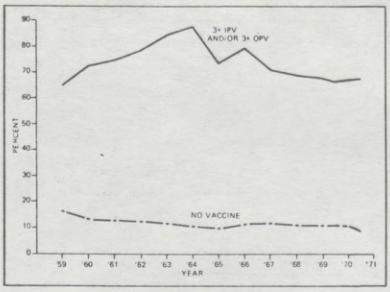

Table 1
Percent of Population, 1-4 Years of Age, Receiving Specified Doses of Diphtheria-Tetanus-Pertussis Vaccine
United States 1962-1971

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
3+ Doses	67.8	72.9	76.0	73.9	74.5	77.9	76.5	77.4	76.1	78.7
No Doses	14.1	12.7	11.4	10.9	10.8	9.3	8.6	7.2	7.0	5.8

Reference

1. Center for Disease Control: United States Immunization Survey 1971, in press

Figure 3
HISTORY OF MEASLES VACCINE, MEASLES INFECTION, AND MEASLES VACCINE AND/OR INFECTION,
1-4 YEAR AGE GROUP
UNITED STATES 1964-1971

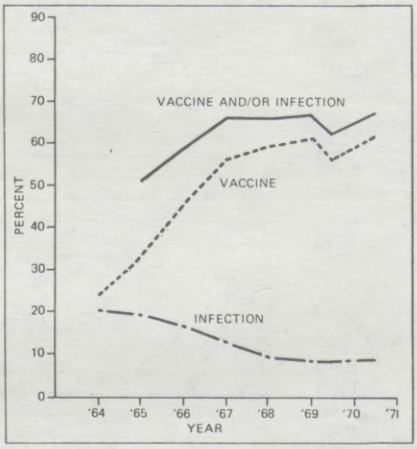

Table 3
Percent of Population, 1-4 Years of Age, with Measles Vaccine, Measles Infection, Measles Vaccine and/or Infection
United States 1964-1971

	1964	1965	1966	1967	1968	1969	1970	1971
Vaccine	24.0	33.2	45.4	56.4	58.8	61.4	57.2	61.0
Infection	20.5	19.7	16.7	12.8	9.7	8.3	8.1	8.7
Vaccine and/or Infection	–	51.0	59.0	66.2	66.0	66.9	62.3	66.6

Table 4
Percent of Population, 1-4 Years of Age, in Poverty Areas Within Central Cities ≥250,000 Receiving Specified Vaccines
United States 1969-1971

Vaccine	1969	1970	1971
Measles	46.1	41.1	48.7
Polio (3+ OPV and/or 3+ IPV)	55.1	50.9	54.3
DTP (3+ Doses)	65.1	55.8	58.4
Rubella	–	41.5	52.0

Table 2
Percent of Population, 1-4 Years of Age, Receiving Specified Doses of Polio Vaccine
United States 1959-1971

	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
3+ OPV and/or 3+ IPV	65.0	72.2	74.3	78.4	84.1	87.6	73.9	78.9	70.9	68.3	67.7	65.9	67.3
No Doses	16.2	13.4	12.9	12.3	11.9	10.2	9.9	11.3	11.7	10.5	10.2	10.8	8.6

Over twenty thousand infants are estimated born each year with defects due to Rh sensitization of the mothers, and five thousand pregnancies each year are estimated to end in stillbirths because of Rh disease.

Mr. ROGERS. Thank you. That is most helpful. We will take into consideration the suggestions of both of you gentlemen. Thank you for being here.

Dr. CARVER. Thank you, sir.

Mr. ROGERS. We have more witnesses, but we will have to go answer the bell, so I think if it is convenient with everyone, we will adjourn until 2 o'clock this afternoon and will resume hearings at 2 o'clock. The committee stands adjourned until 2 o'clock.

(Whereupon, at 12:55 p.m. the subcommittee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m. in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.)

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing our hearings on the extension and revision of the Vaccination Assistance Act.

The Association of State and Territorial Health Officers is submitting a statement for the record which the committee is pleased to have, and without objection it will be made a part of the record at this point.

(The statement referred to follows:)

STATEMENT OF DR. RAYMOND L. STANDARD, IN BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Mr. Chairman, and members of the Committee, my name is Raymond L. Standard, M.D., and I serve as the Associate Director for Health and Operations of the D.C. Department of Human Resources. I am also a member of the Association of State and Territorial Health Officers and it is on behalf of that organization that I am presenting testimony today.

First of all, I want to express the appreciation of this Association for the leadership of the Congressmen who are sponsors of H.R. 14030 and H.R. 14455. We regret that the Department of Health, Education, and Welfare recommended against enactment of the Communicable Disease Control Amendment in 1970. Subsequently, the Department failed to request funds for implementation of the legislation. Since that Act, P.L. 91–464, expires June 30, 1972, there is an urgent need for its extension.

If this legislation is not extended there will be insufficient authorization under the Public Health Service Act for the 1973 budget request for the control of venereal diseases and vaccination assistance unless Sec. 314(d), the authority for comprehensive public health services, is more fully funded. Unfortunately, the budget request for 314(d) is only $90 million for 1973, the same level as appropriated in 1971 and 1972, although the 1973 authorization is $165 million.

NEEDLESS TOLL OF PREVENTABLE DISEASES

A recent report from the PHS Center for Disease Control covering the first 12 weeks of 1972 shows that our Nation continues to be afflicted with a needless toll of deaths and disability due to diseases that could be prevented or controlled. For example, the record shows the following number of reported cases of diseases that could be prevented or controlled with adequate funding.

Reported cases in 1972 as of March 25

Diphtheria	25
Measles (rubeola)	9,100
Rubella	7,785
Tetanus	18
Tuberculosis, new active	5,615
Gonorrhea	152,511
Syphilis, primary and secondary	5,165
Polio, paralytic	5

Furthermore, we know that the number of cases of these diseases reported to the Public Health Service falls far short of the actual incidence. These diseases frequently result in complications that are severe in terms of disability and permanent impairments. The toll in deaths is substantial.

IMMUNIZATION LEVELS

Immunization levels against preventable diseases in children are far too low to oe consistent with good medical care practice. Among children under 5 years of age we find that the national averages of protected children are 69 percent in the case of polio, 47 percent in the case of rubella, and 67 percent in the case of measles. Among individual States the percent under five, who are immunized against these three diseases ranges from less than 25 percent to over 90 percent. And within States, there is a wide range in immunization levels among children.

VENEREAL DISEASES

Venereal diseases in this country have reached epidemic proportions. At least a part of the problem is due to the fact that our control efforts were relaxed following a massive and successful VD control program. In 1961 a strategy for the eradication of venereal diseases was implemented and for four years syphilis declined. The level of Federal support then stabilized at the 1965 level despite cost of living increases. The net effect was a reduction in control programs. In 1972, following substantial annual increases in reported cases of venereal diseases the Department of Health, Education, and Welfare mounted a stepped-up program to combat syphilis. Increased funds toward this end are also provided in the 1973 budget. As I mentioned before, however, there is the problem of insufficient authorization levels if P.L. 91–464 is allowed to expire.

TUBERCULOSIS

In the case of venereal disease the Department of Health, Education, and Welfare has resorted to a crash program to combat the crisis that has developed with respect to syphilis and gonorrhea. We fear that the same crisis will occur with respect to tuberculosis if Federal funds for TB control are curtailed as proposed by the Department.

Tuberculosis, the number one killer among communicable diseases is already showing signs of a future increase due to reduced control programs. In 1970, the number of new cases per unit of population increased among the black population; for the country as a whole the rate of reduction dropped to 5 percent as compared to 8 percent in 1969. Thus, we hope that we will profit by past mistakes rather than repeat them.

A NATIONAL COMMITMENT

Our Association strongly urges a national commitment to combatting diseases that can be controlled or prevented. Such a commitment could be achieved if H.R. 14455 was enacted and adequately funded.

First returns from the uniform national health program reporting system being developed by this Association show a need for additional health education funds. In the case of rubella, only 5 percent of the immunization program funds were spent for public educational activities. In the case of venereal disease con-

trol, only two percent of the program costs were allocated to educational programs.

Consequently, this association strongly supports the provisions of H.R. 14455 that relate to health education programs. We also endorse its other provisions. It is our opinion that the authorizations for appropriations of H.R. 14455 are more adequate and commensurate to the problem than the authorization of H.R. 14030.

Before concluding I must point out the serious situation we face in the District of Columbia relative to our tuberculosis control program. Federal support has been most helpful in our case finding and ambulatory treatment program but with HEW's decision not to support tuberculosis projects, we go from a grant of $1.4 million per year two years ago to zero next year. This is particularly disappointing when we are finally getting on top of our tuberculosis problem. For example, the number of new cases in D.C. dropped from 370 in 1969 to 323 in calendar year 1971.

We urgently request favorable action on this legislation.

Mr. ROGERS. Our next witnesses will form a panel for us to give the benefit of their thinking. I believe we will have three on the panel.

Dr. Lee B. Reichman, director of the Bureau of Tuberculosis, New York City Health Department; Dr. Alan Hinman, who is assistant commissioner of epidemiology and preventive health services for the New York State Department of Health; and Dr. George E. Hardy, Jr., health officer of the Jefferson County Department of Health, Birmingham, Ala.

We welcome each of you gentlemen. We appreciate your being with us and being patient until we could get to you.

I am also very pleased to see Dr. Hardy, who was so helpful to us when the committee held air pollution hearings in your area.

Dr. HARDY. Thank you.

Mr. ROGERS. We welcome all of you, and we will be pleased to receive your testimony.

STATEMENTS OF DR. LEE B. REICHMAN, DIRECTOR, BUREAU OF TUBERCULOSIS, NEW YORK CITY DEPARTMENT OF HEALTH; DR. ALAN R. HINMAN, ASSISTANT COMMISSIONER FOR EPIDEMIOLOGY AND PREVENTIVE HEALTH SERVICES, NEW YORK STATE DEPARTMENT OF HEALTH; AND DR. GEORGE E. HARDY, JR., HEALTH OFFICER, JEFFERSON COUNTY (ALABAMA) DEPARTMENT OF HEALTH; ACCOMPANIED BY CLYDE A. SELLERS, DIRECTOR, BUREAU OF COMMUNICABLE DISEASE CONTROL, JEFFERSON COUNTY (ALABAMA) DEPARTMENT OF HEALTH

Dr. REICHMAN. I am very grateful to have the opportunity to appear before you today to lend my support to H.R. 14455.

I believe this is one of the most important pieces of health legislation to be considered by the Congress in some time because it is so close to a commitment by the Federal Government to do something about those basic medical problems for which cures exist within the context of current knowledge, but that continue to exact an incredible toll of morbidity and mortality. A Federal commitment exists to eradicate cancer and heart disease, both of which will require considerable research to reach that goal. In the communicable diseases on the other hand, that

basic research has been done. Tuberculosis, as you probably know, is a totally curable disease. Of the top 20 causes of death in the United States, it is the only one that is completely understood. We know its pathogenesis, we know how it is transmitted, we know how to prevent the infected from coming down with the disease. We know all these things, that is, no further basic research is required to eradicate this disease. Yet in 1970, tuberculosis killed 5,560 Americans and newly affected 37,137.

In other words, this disease, that medical research has provided us with the wherewithal to eradicate, is still a grave health, economic, and social problem. Tuberculosis provides us with a prism through which to view deficiencies in health care delivery. It is sobering, I feel, when considering Government commitments to eradicate diseases which still require large amounts of research, to look at a disease such as tuberculosis where all the basic research has been done, but where the delivery of the fruits of such research to those citizens, usually the poor and the disadvantaged most in need of it, is clearly deficient.

Contrary to general belief, tuberculosis is not a dying disease. I must contradict Dr. Zapp's contention of an increasing annual rate of decline. From 1969 to 1970, the national incidence of new disease among nonwhites went up 2 percent.

I am releasing at these hearings the figures of new active cases and rates in New York City for 1971. I must admit that some complacency existed in New York with the continued downward trend that we had experienced in previous years, consisting of an 8½-percent falloff between 1968–69 and a 12½-percent falloff between 1969–70. However, our final 1971 figures showed a falloff in new active cases of only 0.7 percent. More significant was the fact that in the Borough of Brooklyn, the number of cases increased 12 percent and in the Borough of Queens, the number of cases increased by 15 percent. Of course, many factors are involved in these statistics including shifts in population groups and hopefully perhaps better case reporting, but the fact remains that in New York City in 1971 only 18 fewer new active cases of tuberculosis were reported than in the previous year; 2,572 new active cases of a totally curable and eradicable disease clearly means that there is much more to do.

I would like to ask that the list of case rates which forms the last page of my testimony appear in the record. (See appendix I, p. 75, this hearing.)

Mr. ROGERS. Without objection, it is so ordered.

Dr. REICHMAN. One more figure to indicate the problem: The new active case rate for central Harlem in 1971, although gratifyingly down 50 percent since 1960, was higher than the rate for New York City as a whole in 1942 (131.8 per 100,000 population compared to 130 per 100,000 population.)

In 1963, the surgeon general appointed a task force to study the status of tuberculosis control in this country. The report of that task force completed in December 1963, contained recommendations for a 10-year plan to raise the level of nationwide tuberculosis control services through greater Federal participation by increased project grants to the States. New York City, acknowledged as having the greatest tuberculosis problem, was a charter recipient of this support.

The specialized combined chest clinics set up and operated with this support have over these 8 years provided comprehensive medical care to the tuberculosis outpatient, enabling New York City to close 600 tuberculosis hospital beds at a program savings of more than $47 million. Before our program started in 1963, only 37 percent of the tuberculosis patients were under current drug therapy. By definition, therefore, the remainder, 63 percent, were out in the community spreading the disease. A repeat analysis in 1971 showed that 98 percent were under current supervision as compared to the national average of 73 percent in 1970. Besides doing their categorical job these clinics bring tuberculosis into the mainstream of medicine by treating at one facility all the patient's medical problems, from heart disease and diabetes to alcoholism, and providing methadone maintenance for his drug addiction, if necessary.

Unfortunately, direct Federal grant project assistance for big city tuberculosis programs under section 317, although amply authorized, had no appropriation of funds for fiscal year 1972. And there are no 314(e) funds for TB control in that area either.

The administration's stance was that with the declining incidence of tuberculosis, State and local funds for tuberculosis control activities could be adequately supplemented by the Federal health funds available under section 314(d) of the partnership for health legislation. Our experience in New York City reveals, however, that this is simply not true. With the cutoff of Federal funds for fiscal year 1972 the city of New York loses the $764,000 which finances its eight combined chest clinics; $630,000 of formula grant money under section 314(d) will continue, but the State's 314(d) funds for the next fiscal year have been decreased by $29,700, and this must still fund other vital upstate health programs based on upstate priority. Consequently the formula assistance to New York City from the State under 314(d) cannot be augmented.

That is, the broad flexible authority that Dr. Zapp spoke of does not find its way down to the local areas where it is mostly in need.

Unless other funding is found, New York City faces an unparalleled health crisis resulting in the closing of our eight combined chest clinics which give comprehensive care to 6,500 complicated tuberculosis patients. The result clearly will be a decrease in tuberculosis surveillance, requirement for longer hospital stay, and ultimately a reversal in the downward trends in this disease that we have all been so proud of.

The example of venereal disease should not be forgotten by this subcommittee. One of the major determinants of the shocking rise in venereal disease cases which is also addressed by the legislation under consideration was a marked diminution of Federal support in the mid-1960s—I call to your attention the chart over to your left, Mr. Chairman—largely because of complacency brought on by an earlier rapid falloff of cases. This, in turn, had been brought about by an input of Federal funds and personnel. We cannot afford to let history repeat itself with tuberculosis.

One of the most notable factors in the legislation under consideration is the fact that tuberculosis is mentioned specifically with a specific authorization. Let me plead that this must be maintained to give the best chance to get an appropriation for tuberculosis control, without which at least 18 big city tuberculosis programs, now cut off from support under section 317, will be devastated.

The last point I would like to address myself to is the concept of categorical care versus comprehensive care. I suspect that the administration would take funds saved from categorical programs to be used in developing health maintenance organizations. Speaking for myself I must applaud any efforts taken by our Government to bring health care to the large groups of people who do not have ready access to it. Health maintenance organizations may well be an answer to these problems.

Where categorical illnesses fit in, however, is a different problem. Tuberculosis has always been categorical. Historically, and to a great extent at present, tuberculosis has been handled outside the mainstream of medicine. Dr. Dieter Koch-Weser of the Harvard School of Public Health has found marked deficiencies in medical education pertaining to tuberculosis throughout the country's medical schools.

Our program in New York City has been designed to return tuberculosis to the mainstream of medicine by bringing comprehensive care to the tuberculosis patient, in the context of his tuberculosis, where he will be a captive of the medical care system for his 2 years of therapy. We use internists and community-oriented physicians who enthusiastically care for the tuberculosis patient and his family as whole individuals. As an example, New York City's exciting new hypertension screening and treatment program, as far as tuberculosis patients are concerned, will be dealt with entirely in our combined chest clinics without the use of expensive specialized treatment centers except in unique complicated cases.

My caution is that until the health maintenance concept is fully implemented and functioning for all patients, the administration's rush to support it should not take funding away from those categorical diseases which cannot be adequately cared for by an interim system. One cannot change a disease whose basis has always been categorical into one what is treated in a comprehensive setting overnight.

I wish at this time to express my sincere gratitude to the committee for inviting me to express my feelings and those of the Health Department, Health Services Administration of New York City.

(Appendix I, referred to, follows:)

APPENDIX I

NEW ACTIVE TUBERCULOSIS CASES REPORTED, BY BOROUGH AND HEALTH DISTRICT, OF RESIDENCE NUMBERS AND RATES, NEW YORK CITY, 1969–71

Health district	Number			Rate per 100,000 population [1]		
	1969	1970	1971	1969	1970	1971
New York City	2,951	2,590	2,572	37.4	32.8	32.6
Manhattan	1,045	957	884	67.9	62.2	57.4
Central Harlem	280	247	241	153.2	135.1	131.8
East Harlem	107	78	71	68.2	49.7	45.2
Kips Bay-Yorkville	42	30	30	18.3	13.1	13.1
Lower East Side	[2] 232	[3] 225	[4] 208	93.0	90.2	83.4
Lower West Side	151	141	124	59.6	55.6	48.9
Riverside	132	128	122	59.9	58.1	55.4
Washington Heights	101	108	88	40.8	43.6	35.6
Bronx	519	510	426	35.3	34.6	28.9
Fordham-Riverdale	32	33	25	13.1	13.6	10.3
Morrisania	171	153	139	65.3	58.4	53.1
Mott Haven	136	129	111	64.0	60.7	52.2
Pelham Bay	39	32	32	18.9	15.5	15.5
Tremont	84	118	85	32.4	45.6	32.8
Westchester	57	45	34	19.7	15.6	11.8
Brooklyn	998	796	894	38.4	30.6	34.4
Bay Ridge	38	23	27	14.0	8.4	9.9
Bedford	213	207	200	77.0	74.9	72.4
Brownsville	154	140	144	48.3	43.9	45.2
Bushwick	123	78	128	53.5	33.9	55.7
Flatbush	84	60	72	17.2	12.3	14.7
Fort Greene	152	109	131	76.4	54.8	65.8
Gravesend	61	40	35	19.3	12.7	11.1
Red Hook-Gowanus	63	55	46	44.7	39.0	32.6
Sunset Park	53	38	40	28.7	20.6	21.7
Williamsburg-Greenpoint	57	46	71	32.4	26.2	40.4
Queens	348	287	330	17.5	14.4	16.6
Astoria-Long Island City	44	32	62	17.6	12.8	24.8
Corona	66	62	60	25.8	24.2	23.5
Flushing	45	35	45	9.3	7.2	9.3
Jamaica East	99	82	97	28.8	23.8	28.2
Jamaica West	57	50	38	15.8	13.9	10.6
Maspeth-Forest Hills	37	26	28	12.5	8.8	9.5
Richmond	41	40	38	13.9	13.5	12.9

[1] 1969, 1970, and 1971 rates are based on 1970 Census of Population.
[2] 1969 includes 98 homeless men.
[3] 1970 includes 102 homeless men.
[4] 1971 includes 89 homeless men.

Mr. ROGERS. Thank you very much, Dr. Reichman. We appreciate your presence here. The facts you have given us will be most helpful.

Dr. Hardy, do you wish to proceed.

Dr. HARDY. Dr. Hinman will be next.

STATEMENT OF DR. ALAN R. HINMAN

Dr. HINMAN. I am Dr. Alan Hinman of the New York State Department of Health. As assistant commissioner for epidemiology and preventive Health Services I am responsible for the communicable disease control programs administered by the State health department. I would like to testify in favor of continuing categorical assistance for communicable disease control programs, specifically under H.R. 14455. Although we feel that block grant funding may be preferable to categorical funding, this has not worked out in practice. There may be several reasons for this, but two factors come immediately to mind. The first is that when categorical support has been discontinued, as with the Vaccination Assistance Act in 1969, there has not been a commensurate increase in block grant funds. The other is that communicable disease control programs, being primarily aimed at prevention and having already achieved a considerable degree of success in many areas, are not very visible and thus often have difficulty in competing for general purpose funding.

Let me first talk about venereal disease control and then say a few words about immunizations and tuberculosis control. Attachment 1 shows the number of cases of infectious syphilis reported in New York State since 1950. You can see there has been a dramatic rise in the incidence in the past few years, with 1970 representing a 40-percent increase over 1969, and 1971 an additional 6-percent increase over 1970. For 25 years we have had effective means for treating syphilis and, in the mid-1950's, we had fairly good control over it. Why are we not doing as well now? One answer is that, like most other States, we have relied very heavily on Federal support for our syphilis control activities. During the early 1940's we received a considerable amount of Federal support, but toward the end of the 1950's this support was drastically reduced, with a consequent rise in the number of cases.

Federal support was increased in 1962–63 and, as you can see, there resulted a striking decline in the number of cases. Unfortunately, however, in the past few years this support has once again declined, if not in actual dollar amounts at least in terms of purchasing power, and we are now seeing the result of this diminution. As a specific example of the correlation between the incidence of syphilis and the level of support, let me ask that you look at attachment 2, which shows the number of cases of infectious syphilis in New York State excluding New York City and the number of Federal veneral disease investigators assigned to the upstate program. You can see that in 1960 there was a striking increase in the number of cases of syphilis and that this increase continued through 1963. The number of cases are shown in the solid line. The number of investigators are shown in the dotted line.

The number of venereal disease investigators assigned in the State did not begin to increase until 1962 and reached its peak in 1964. As the number of VD investigators rose to its peak, a downward trend in the incidence of syphilis was brought about. Unfortunately, however, the decline in the number of investigators was just as rapid as the decline in the number of cases and in the past 2 years we have seen an increase in the incidence of syphilis with which our investigators have been unable to cope. I believe this graph shows that by putting enough

men on the job we can control syphilis, but that it is necessary to maintain an adequate work force in order to maintain control.

As Dr. Brown from CDC has said, the program was eradicated before the disease was.

Turning now to gonorrhea, attachment 3 shows the rising incidence of gonorrhea in New York State over the past 20 years. Gonorrhea is truly epidemic in New York as it is in the rest of the Nation. We have more than doubled the number of cases reported in the last 9 years and presently we are having a case of gonorrhea reported every 11 minutes in the State. In 1971 there were more than 55,000 cases reported. This figure becomes even more alarming when it is realized that only about one-sixth of cases seen by physicians are actually reported to the health department. Therefore, we can estimate that in excess of 300,000 cases of gonorrhea actually occurred in New York in 1971. This is equivalent to about 1.5 percent of the population of the State regardless of age.

Mr. ROGERS. You mean that is just in New York State?

Dr. HINMAN. New York State.

Mr. ROGERS. Do you think that 600,000 is a realistic figure nationwide?

Dr. HINMAN. That is clearly an underestimate.

Mr. ROGERS. Of course. If you have 300,000 in one State alone——

Dr. HINMAN. That is correct. CDC has estimated there are well in excess of 2 million cases of gonorrhea. I think that is a more realistic estimate of the number of cases.

Mr. ROGERS. I think they are using that 600,000 figure, aren't they?

Dr. HINMAN. That is the official figure, sir. That is the number of cases reported. However, two nationwide surveys—one done in 1963 and one in 1968—by the American Social Health Association in conjunction with CDC showed that physicians actually reported only about one-sixth of the cases they saw nationwide.

The graph shows that at no time in the past 20 years have we had any real control over gonorrhea. The reasons for this are multiple and include the short incubation period of the disease, difficulties in diagnosis, lack of a blood test, and, most importantly, lack of financial support. Our Federal support in the past, though titled "Venereal Disease Control," has in reality been aimed almost exclusively at syphilis control.

There can be no question regarding our need for Federal support for venereal disease control activities. We are presently spending $2,750,000 a year in State and local funds for venereal disease control and, given the current fiscal situation with the State, it seems quite unlikely that there can be any significant increase in that amount. Clearly, faced with the ever-increasing incidence of syphilis and gonorrhea, additional help is needed. We presently receive just under $1.1 million from the Federal Government for syphilis control activities and have been told that we will receive about $1.8 million for gonorrhea control activities under the Communicable Disease Control Amendments of 1970. That is 317 money—the $1.1 million we presently receive is 314(e). This latter amount should be a great help in beginning the job of controlling gonorrhea, but, as you are well aware, this act expires at the end of the current fiscal year.

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Of the total $240 million approved for the 3-year life of the Communicable Disease Control Amendments, only $22 million has been appropriated: $2 million for tuberculosis control in fiscal year 1971 and in fiscal year 1972, $4 million for immunization activities and $16 million for venereal disease control. It might be pointed out here that the national commission on venereal disease has recently recommended expansion of Federal support for VD control to $46 million in fiscal year 1973, $54.8 million in fiscal year 1974, and $60.5 million in fiscal year 1975. We support these recommendations and urge that you continue specific support for VD control and fund it at the level recommended by the national commission.

Turning now to the immunizable diseases, we see once again that Federal support under a categorical program has played a very important role in our achievements. One of the best examples of this is seen with measles.

Mr. ROGERS. The bells are ringing for a vote. We only have 10 minutes to make it. So we will have to recess for 10 minutes. I am sorry.

(A brief recess was taken.)

Mr. ROGERS. Let us continue.

Dr. HINMAN. The Vaccination Assistance Act expired in 1969 and Federal funds were no longer available for States to purchase measles vaccine. The Federal Government shifted its emphasis and its categorical support to the new rubella vaccine. Measles and other immunizations were then supposed to be covered by block grant funding, but our block grant was not correspondingly increased. The State of New York followed the Federal lead and State appropriations for measles vaccine also ended in 1969, to be replaced by appropriations for rubella vaccine. Instead of receiving measles vaccine free, either from the Federal Government or the State government, local health departments now found themselves having to purchase it. Federal immunization representatives, who had been of great assistance in carrying out the measles immunization program, were told that their job was to organize rubella immunization programs. No one had made a long term commitment to carry through the measles eradication campaign—at least no one who was dispensing money.

One result of this drop in support can be seen in the following table:

Number of measles immunizations in public clinics, New York State, 1966–70

Year:	*Number of immunizations*
1966	281,354
1967	270,281
1968	258,232
1969	182,232
1970	180,187

There was a marked decline in 1969 compared with 1968. Attachment four chronicles the progress of the measles immunization program in New York State exclusive of New York City, which I shall call upstate New York. It shows the quarterly number of reported cases of measles (dotted line) and the cumulative number of doses of measles vaccine administered in public clinics (solid line). The curve showing the cumulative number of doses of vaccine clearly has two slopes: A relatively rapid and continued rise from the end of 1965 to the beginning of 1969, and a uniform slowing of this rise starting in

1969. Following the slowing of the rate of immunizations, there was an increase in the incidence of measles.

In 1971 statewide we had three times as many cases of measles as we had in 1970.

Mr. ROGERS. Could you repeat that?

Dr. HINMAN. Three times as many cases in 1971 as we had in 1970.

This same trend has been seen nationwide, both in terms of levels of immunity and in terms of incidenct of measles. The National Immunization Survey, conducted by the Bureau of Census showed a drop in the proportion of 1- to 4-year-old children immunized against measles from 61.4 percent in 1969 to 57.2 percent in 1970, a drop of 4 percent in 1 year. Looking at the 1- to 4-year-olds in central city poverty areas, the drop was from 46.1 percent to 41.1 percent. The national incidence of measles increased from 25,286 in 1969 to 47,351 to 75,007 in 1971 (provisional figures).

Nationwide over a 3-year period we have had a threefold increase in the incidence of measles.

Mr. ROGERS. What is the outlook for this year?

Dr. HINMAN. For this year in New York State we are presently running a little bit lower than we were last year, sir. The number of cases is only about one-third this year what it was last year at the same time. Although it may be said that this is due to our renewed efforts, I think one also must keep in mind that measles is a cyclic disease which does not have epidemics every year.

My own opinion is that a good share of the reduction we are seeing this year is more the result of the natural periodicity of measles than it is reflecting our increased activity.

Mr. ROGERS. How much increased activity this year over last would you say?

Dr. HINMAN. A considerable amount. In July of last year because of the lower than anticipated cost of rubella vaccine, 314(e) moneys were allocated for the purchase of measles and polio vaccine. So we were for the first time in 2 years able to purchase measles vaccine for use in clinics throughout the State. We have had a considerable increase in the rate of measles immunization throughout the State since then.

I can't give you the exact percentages at this point, sir, but there has been definitely an increase in immunization.

Due to the lower than anticipated cost of rubella vaccine, a decision was made last year to allow unexpended rubella grant funds to be used for the provision of other vaccines. This has been a big help in attempting to remedy this problem, as has been the appropriation of $4 million from the communicable disease control amendments. However, this support is uneven and is presently due to terminate as of June 30. It has also depended on the fluctuation in the marketplace of rubella vaccine, which is nothing that one can plan for.

At this point I should like to mention the statement made by the Action Committee for Childhood Immunizations, of which I am a founding member. This statement is included as attachment 5. The New York State Department of Health endorses this statement which calls for a continuing commitment at all levels of government to support immunization activities. The American College of Preventive

Medicine and the Infectious Disease Committee of the American Academy of Pediatrics have also endorsed this statement.

Funding for tuberculosis control activities has also had an uneven course and there is presently no categorical support for tuberculosis control. As you heard from Dr. Reichman, I am happy to be able to tell you that there has not been a corresponding increase in the incidence of tuberculosis, but as we know this to be a disease characterized by slow rather than rapid changes, I do not feel particularly sanguine about its future should continuing financial support not be provided.

In closing, I would like to reiterate the critical need for continuing Federal support for communicable disease control activities. Our experience with block grants in the past has not provided the level of support needed.

The results of successful programs are not highly visible since our goal is that people not get venereal disease or tuberculosis, that children not be crippled or killed by polio, diphtheria, or measles, and that infants not be born with congenital defects due to maternal rubella infection. I urge you to provide the continuing commitment required to eliminate these diseases as public health problems.

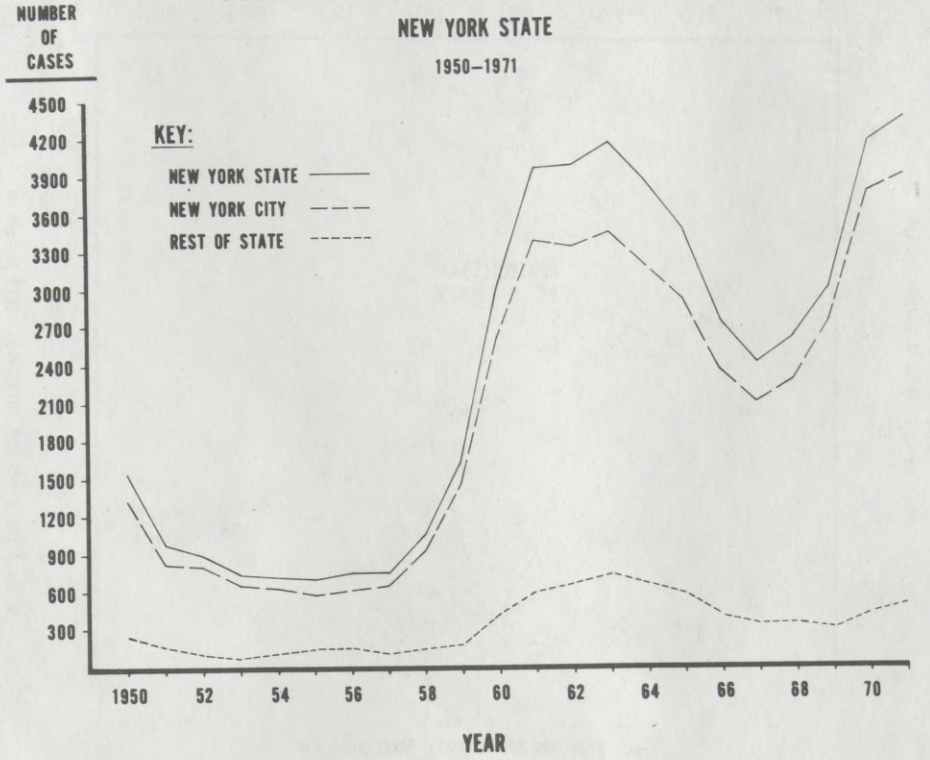
Thank you very much.

(The attachments referred to follow:)

PRIMARY AND SECONDARY SYPHILIS

NEW YORK STATE

1950–1971



N.Y.S. DEP'T. OF HEALTH

MARCH 1972

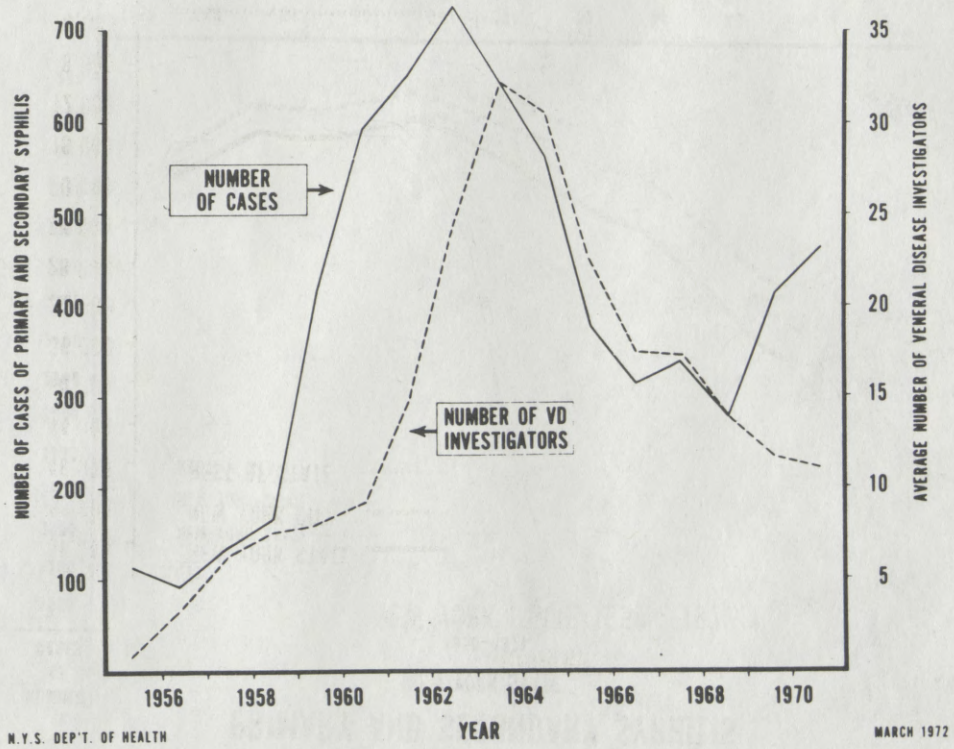
ATTACHMENT 1

PRIMARY AND SECONDARY SYPHILIS

AND AVERAGE ANNUAL COMPLEMENT OF VD INVESTIGATORS

NEW YORK STATE (EXCLUSIVE OF NEW YORK CITY)

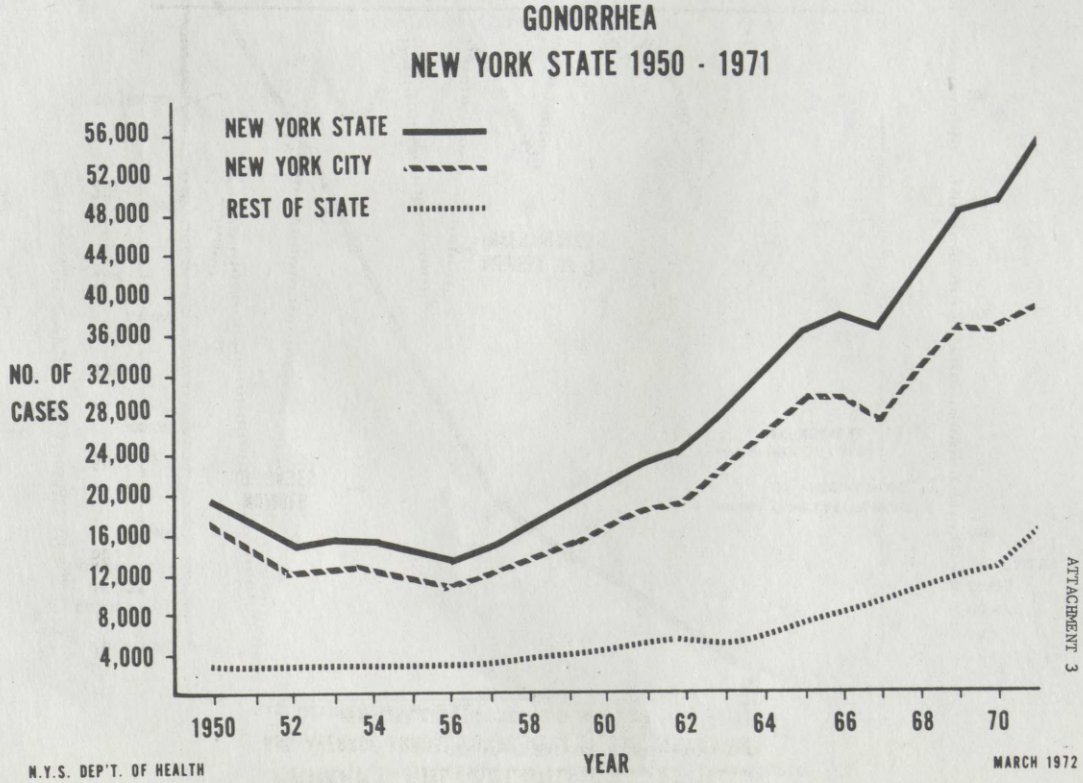
1956 – 1971



N.Y.S. DEP'T. OF HEALTH

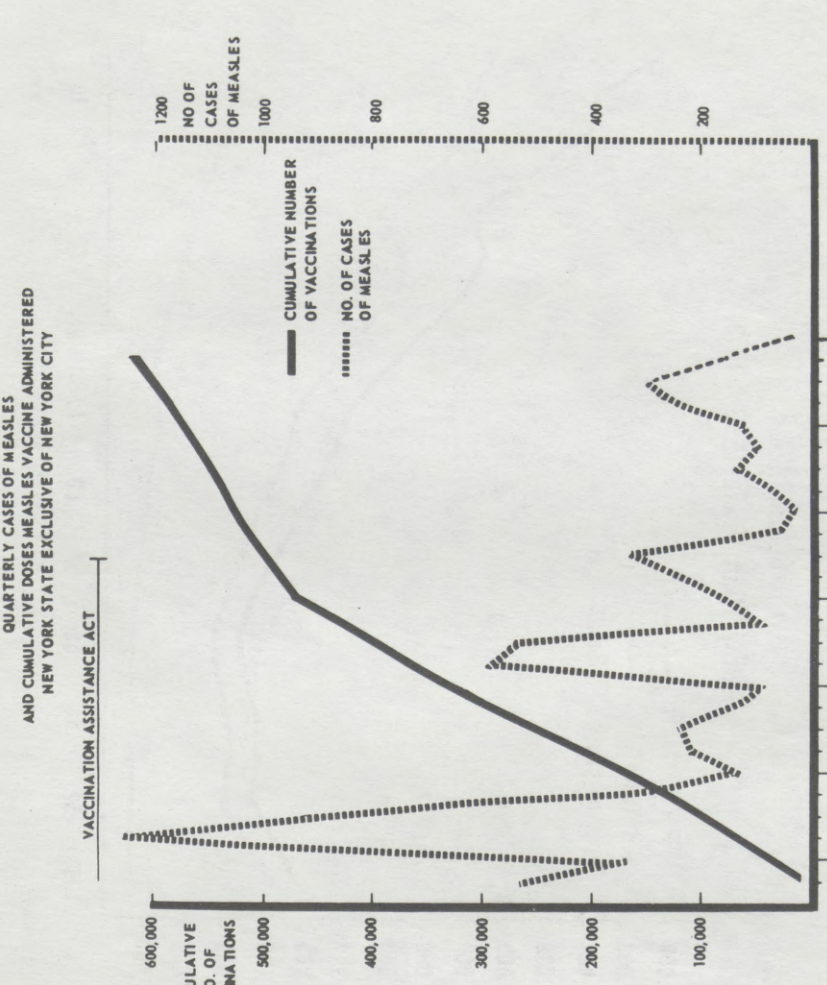
MARCH 1972

ATTACHMENT 2



ATTACHMENT 3

ATTACHMENT 4



ATTACHMENT 5

Action Committee for CHILDHOOD IMMUNIZATIONS

(Measles, Diphtheria, Whooping Cough, Tetanus, Polio, Rubella, Mumps)

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RESOLUTION

We, the undersigned, have met as an ad hoc committee because of our concern with the deteriorating state of communicable disease control in this country. There has been a 400% rise in the incidence of measles over the past four years, recent outbreaks of diphtheria, an imminent threat of outbreaks of polio, and a decline in immunity to tetanus and whooping cough.

This situation is deplorable since these diseases are preventable by immunization. We believe the factors responsible for this situation include:

1. The lack of a long-term federal commitment, at the highest levels, to communicable disease control. This is reflected by the token-funding of Public Law 91-464 (the Communicable Disease Control Amendments of 1970), the failure to provide specifically for immunizations in the presently proposed national health insurance plans, and the shifting emphasis of federal support from one disease to another over the past several years without maintaining a coordinated approach to all.
2. The lack of state and local resources to maintain adequate control programs.
3. The lack of sufficiently aggressive immunization practices by physicians and other health personnel.
4. The lack of recognition by the public that simple and effective measures of prevention are available.

We therefore urge:

1. National recognition of this situation and a long-term federal commitment to a coordinated plan for the control of communicable diseases. This plan should include provision of vaccines, personnel, and the support of a nationwide education program.
2. Increased effort on the part of state and local health agencies and practicing physicians to support and expand immunization programs.
3. Expert immunization advisory groups, such as the Public Health Service Advisory Committee on Immunization Practices and The American Academy of Pediatrics Committee on Infectious Diseases, should consider the overall approach to raising national levels of immunity in addition to technical aspects of vaccines.

Original Copy Signed By All Members Of The Committee

(Atlanta, Georgia, August 24-25, 1971)

Mr. ROGERS. Thank you very much. I think it would be helpful if we could get just what funds and in what categories New York State has gotten, say, in the last 3 or 4 years and this year as well. You may put it in the record if you would like.

Dr. HINMAN. At the present time we are receiving under the 314(d) mechanism block grant funding for health purposes a total of $5.1 million. Of this amount about one-quarter is allocated for tuberculosis control. The remainder is spent on our health guide outreach program, district and regional health personnel, water pollution control, and harbor surveillance activity.

There are two communicable disease programs included in our categorical block program at the present time. Under the 314(e) mechanism for rubella we are receiving statewide $3.1 million; syphilis control, $1.1 million. Under the 317 mechanism, although we have not yet heard definitely about the funds, we have an idea about how much we will be getting. For venereal disease this will be $1.18 million; for immunization, $500,000.

Mr. ROGERS. Then you can put down what you really think you need to do an adequate job.

I have to go vote again. I am sorry. So we will recess another 5 or 10 minutes.

(A brief recess was taken.)

Mr. ROGERS. We will come to order.

Our next witness is Dr. George E. Hardy, Jr. We are glad to have you with us.

STATEMENT OF DR. GEORGE E. HARDY, JR.

Dr. HARDY. Thank you, Mr. Rogers.

We appreciate your continued return so that we all present our comments.

My name is George E. Hardy, Jr. I am a physician and serve as health officer for the Jefferson County, Alabama Department of Health, 1912 Eighth Avenue South, Birmingham, Ala. 25233. With me today is Mr. Clyde A. Sellers, director of our bureau of communicable disease control.

Mr. Chairman, it is indeed an honor for me to appear before your subcommittee once again and to have an opportunity to offer our support for H.R. 14455, one of the communicable disease control bills being considered today, by briefly presenting the problems local public health workers face in dealing with communicable disease control. The figures which I shall present are those of Jefferson County, Alabama's largest county, with a population of 645,000, but the circumstances in which we find ourselves are in no way unique.

As you know, communicable disease control has long been a hallmark of public health. The diseases with which we deal are not always exotic, they frequently attack individuals with limited access to medical care and, most importantly, they have the distinct disadvantage of being not only harmful to the individual so infected, but a threat to the public health as well by virtue of the very nature of their transmissibility. Treatment for a single infection implies far more than an individual therapeutic regimen. The concepts of disease surveillance, case finding, epidemiologic investigation, prophylactic treatment, mass or selected community immunization programs, and even quaran-

tine may be involved. These concepts and activities are far beyond the scope of the individual medical practitioner's office, and are so specialized and unique as to warrant continued categorical attention and support.

Permit me to review briefly three areas of communicable disease control activity in Jefferson County—venereal diseases; diseases for which immunizable agents are routinely employed; and tuberculosis.

VENEREAL DISEASES

We have been told that the number of reported cases of venereal disease has reached epidemic proportions in the United States; that gonorrhea has become our most common communicable disease, second, if one is a purist, to the common cold; that the incidence of venereal disease is particularly prominent among individuals in the 20- to 24-year-age group and occurring with ever-increasing frequency in our teenage population; and that until a successful vaccine for syphilis and rapid serologic screening for gonorrhea become a practical reality, we will have to rely on our current epidemiologic approach to venereal disease control.

In Jefferson County our experience has paralleled these national trends. Mr. Chairman, we have prepared several graphs that we would like to introduce at this time. They have been reproduced in our handout and I would like to ask that they be entered into the record.

Figure 1 (see p. 92) shows our reported cases of syphilis and gonorrhea plotted as case rates per 100,000 population at 5-year intervals for the past decade. As can be seen in figure 1, the gains we have made in syphilis control between 1961 and 1971 are dramatic. In 1967 Birmingham had the rather dubious distinction, along with others we have had recently, of ranking first in the Nation in primary and secondary syphilis case reports. However, by 1971 we had dropped to 58 among 60 cities with populations of 200,000 or more. This achievement could never have been realized without national program emphasis and concomitant funding to support our epidemiologic interviews and prophylactic treatment programs.

Mr. ROGERS. How many cases does it still represent, however?

Dr. HARDY. There were 100 reported cases of primary and secondary syphilis in the county.

Mr. ROGERS. One hundred?

Dr. HARDY. Yes, sir.

Mr. ROGERS. Thank you.

Dr. HARDY. Unfortunately, as is the case nationwide, our experience with gonorrhea control has not been as good. In fact in 1971, our case rate was more than twice the national average. On May 1 of this year we will initiate a recently authorized Federal gonorrhea control program—which I am pleased to note has roots in this very subcommittee—that we trust will be able to help us improve upon the current situation.

As the problems attendant with venereal disease control and the complications of these diseases are known to this committee, and as there have been others appearing before you today with greater experience in venereal disease control than I, I would note only that our hoped-for reduction in gonorrhea, like our actual reduction in syphilis, will be a transient, temporary phenomenon without a permanent Fed-

eral commitment to the control of venereal diseases and to a national program of health education embracing the study of these diseases early in one's school years.

IMMUNIZATION ACTIVITIES

In presenting our experience in the area of diseases for which immunizable agents are routinely employed, I speak not only as a local health officer, but as secretary for the national Action Committee for Childhood Immunizations, that Dr. Hinman referred to earlier. This committee, composed of young physician epidemiologists from across the United States representing State and local health departments, university medical centers, and the private practice of medicine, is concerned about the decline in childhood immunization rates in this country—a decline clearly documented by the Federal Government's own annual immunization surveys.

Parenthetically, I would also note that all three of us on this panel at one time or another were exposed to or trained in public health communicable disease control activities because of the programs of the National Center for Disease Control. I think that of all the Federal health programs which exist today, this Center is the one most responsible for developing young physicians' interest in public health and preventive medicine.

Mr. ROGERS. All three have already been claimed by Dr. Sencer. He wanted me to ask you how you got into preventive medicine.

Dr. HARDY. There are a great many more besides the three of us.

The Action Committee has noted that:

(1) Vaccines are available which can protect every child in the United States against well-known crippling and killing diseases;

(2) Cost benefit studies clearly demonstrate that the gains from immunization procedures are among the greatest to be achieved from existing public health practices;

(3) We are not now effectively or comprehensively protecting American children with available vaccines; and,

(4) National recognition of this situation and a long-term Federal commitment to a coordinated plan for the control of communicable diseases are needed.

In Jefferson County, our federally-funded immunization project was organized late in 1964. At the time of its inception less than 79 percent of county newborns were receiving any immunization against diphtheria, tetanus, whooping cough, or polio. Since the implementation of our project, 93 percent of county newborns are beginning immunization against these particular diseases; and, since the introduction of our delinquent immunization followup for high risk areas in 1969, we have achieved an overall level of 80 percent for such individuals completing their initial immunization series. In fact, this past calendar year was the first time in recent history that Jefferson County has not had a case of either diphtheria or tetanus. Unfortunately, however, with our currently reported national immunization levels—particularly in certain segments of our population, it will not be at all surprising to see continued outbreaks of diphtheria and tetanus as well as measles and even polio unless these immunization programs are retained and intensified.

It is also as a result of the Federal immunization program that many local health jurisdictions have been able to offer new vaccines to the public as they become available. In 1965 and 1966 when the Federal effort to eradicate measles was first launched, we, like most health districts across the country, conducted a mass measles immunization program with vaccine and personnel provided under the Vaccination Assistance Act.

Figure 2 (see p. 93) shows our experience with measles control by depicting reported cases for three selected measles epidemiologic years (defined by the National Center for Disease Control as the 41st week of a given calendar year through the 40th week of the next consecutive calendar year) in the past decade. In 1960–61, we were still in our prevaccine era and experiencing measles outbreaks every 2 to 3 years which, prior to widespread vaccine use, was the typical urban pattern. The next period shown, 1965–66, was shortly after measles vaccine had been introduced in a countywide program. In a subsequent year, not shown on this graph, we actually reached a level of zero (0) reported cases.

Then in 1968, the Federal Vaccination Assistance Act expired. After "carry-over" funds were expended in 1969, there was no further direct funding for measles immunization activities. Since 1970, there has been a small release of additional funds for measles vaccine, but such unpredictable fiscal action does not promote sustained activity or careful planning. Furthermore, the lack of continuity of funding for all vaccines has made immunization practice subject to fads. It was no coincidence that money for measles immunization waned when a new vaccine against rubella was introduced. In short, the measles eradication program was eradicated before the disease.

What this meant for Jefferson County was the epidemic resurgence of a totally preventable illness (again depicted in figure 2) and, the tragic loss of life of two of our young American citizens. And this, solely because a real commitment to a proved preventive measure had not been sustained.

Please do not misconstrue my comments as being opposed to our current rubella immunization activities, but rather to indicate that a total, continuing, comprehensive immunization program must be funded and maintained. I do feel that the dollar amounts included in H.R. 14455 are appropriate.

TUBERCULOSIS

Tuberculosis control is the final area I would comment upon today. Tuberculosis case rates have undergone dramatic reduction in Jefferson County during the past decade. However, even with a nearly 50 percent reduction in new active case rates during that 10-year period, tuberculosis remains a major public health problem.

As is true in many local health jurisdictions, our department has primary responsibility for tuberculosis control activities. Our program includes identification and epidemiologic follow-up of cases, disease surveillance monitoring, and direct patient supervision in a series of free standing clinics necessitating the skills of a multidisciplinary staff, laboratory and radiologic support services, and prescription drugs. In 1970, we had nearly 25,000 tuberculosis clinic visits, and, as

is so often true, the majority of our new cases occurred in the lower socioeconomic segment of our population; that is, that segment of the population with the least access to medical care.

I am sorry that Dr. Zapp is no longer here to see what the real effect of abolishing categorical disease programs has been.

As you know, specific categorical program support for tuberculosis control was reduced in 1968 and essentially eliminated in 1969. At that time, Birmingham, ranking 48th in the Nation in population, ranked 26th in the Nation in the actual number of new active cases reported, and fourth in the Nation in new active case rates. As you can see in figure 3 (see p. 94), the new active case rate for the city of Birmingham in 1971 was still nearly three times the national average.

This, then, is the status of a program for which Federal funds were withdrawn, and withdrawn at a time when real gains were being made. With the termination of categorical funding, our State lost over $864,000 in tuberculosis control money, (more than $500,000 from a statewide grant, and $300,000 from a Jefferson County grant) while at the same time receiving an increase of only $422,000 in its "block funding" under 314(d). Of that amount, the State chose to allocate only $250,000 for tuberculosis control statewide and Birmingham received only $40,000 of this. Our city, with the fourth highest new active case-rate in the Nation went from a $300,000 program to one of $40,000.

Every State in the southeastern region, save one, lost much-needed tuberculosis assistance as a result of this shift in funding; the areas which suffered most were areas such as Alabama where the prevalence of tuberculosis is greatest.

In the past, categorical grant awards have been made on the basis of population and need; block grant distribution, on the other hand, simply has not met tuberculosis needs in those areas of the United States having the highest incidence of new active tuberculosis cases. It somehow makes very little sense to me to reallocate communicable disease control funds merely for the sake of philosophical change, that is, categorical to block funding, when such reallocation removes health dollars from areas where the problems are most severe.

Gentlemen, I would emphasize again that while our case rates are high, our experience in tuberculosis control is not unique. It will be

a few years before the full effect of the withdrawal of this categorical program is felt—because of the natural history of the disease itself—but if it is not now reinstated, in time we will see developing a picture very much like that of the explosive reappearance of syphilis in 1957, and the unprecedented resurgence of measles in 1969 following the withdrawal of previous Federal commitments. When the full extent of this funding error is finally recognized and the program, of necessity, is reinstated, it will be at a higher fiscal level than is currently necessary, and with a loss of all that has been gained to this point in time. I do hope we will learn from our lessons of the past and not eliminated a categorical program when a job is still to be done.

The amounts requested for tuberculosis control in H.R. 14455 are not sufficient. I would encourage your consideration of an increased authorization by at least 50 percent in this area.

SUMMARY

In conclusion, I would note that the themes I have tried to develop today are:

1. that communicable diseases are unique—they affect not just an individual, but the public at large, and, as such, need special, categorical attention and, yes, categorical support;

2. that the experiences of our health departments are in no way unique; that they in all likelihood closely parallel those of health departments providing service to the very constituencies which each of you represent;

3. that we must cease "program eradication" and fad funding each time a goal appears in sight; and,

4. that only with a long-term Federal commitment to the control of these diseases, which recognize no local or State boundary, can we hope to achieve the results which we all desire.

Gentlemen, I urge you to act swiftly and positively on the bill under consideration. Again, I thank you for the opportunity to be here today.

(Figures 1, 2, and 3, referred to, follow:)

Fig. 1

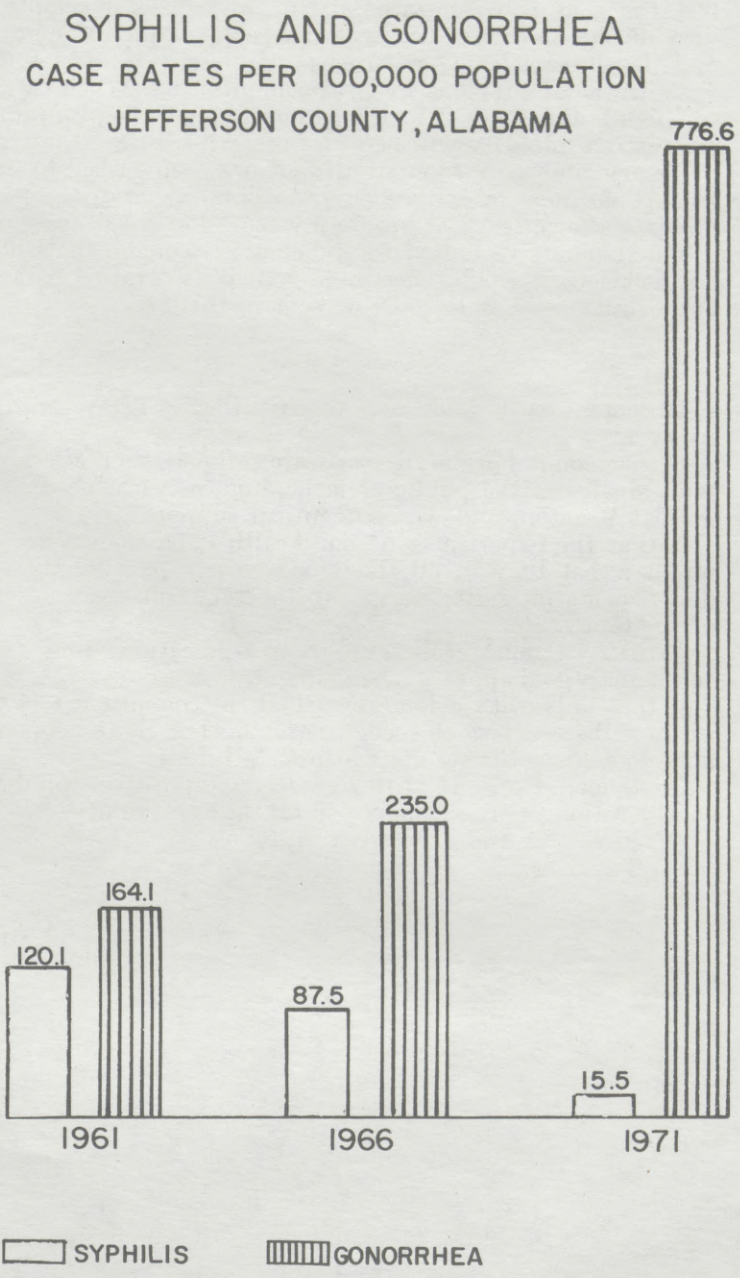
SYPHILIS AND GONORRHEA
CASE RATES PER 100,000 POPULATION
JEFFERSON COUNTY, ALABAMA
776.6
235.0
164.1
120.1
87.5
15.5
1961
1966
1971
SYPHILIS
GONORRHEA

Fig. 2

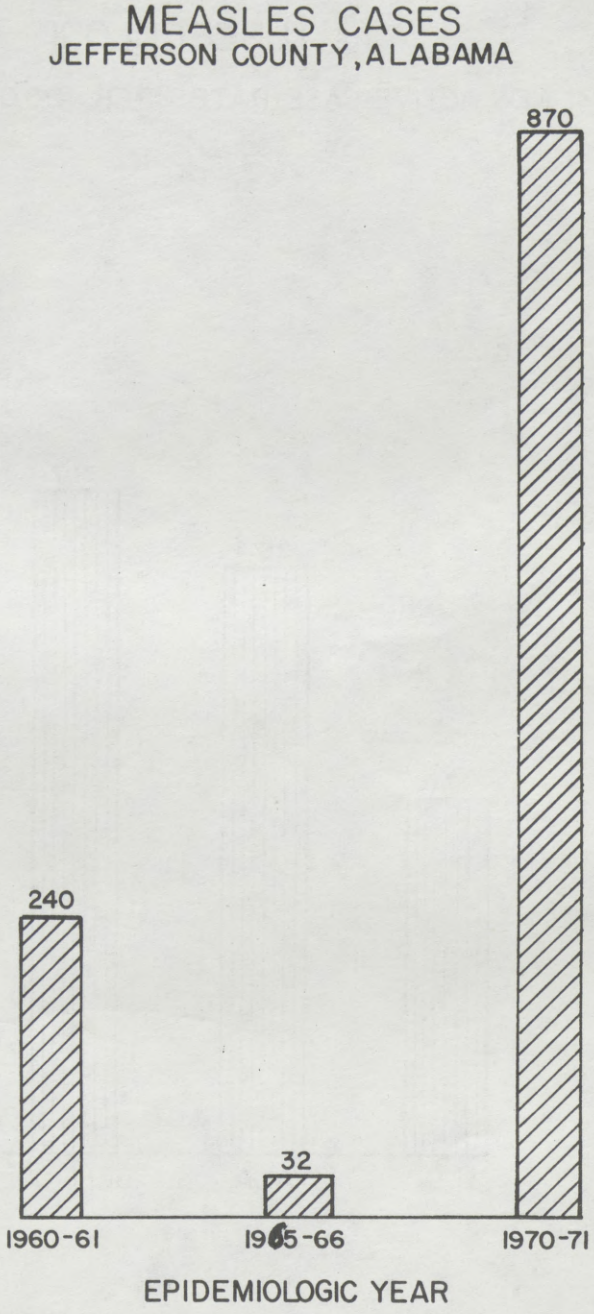

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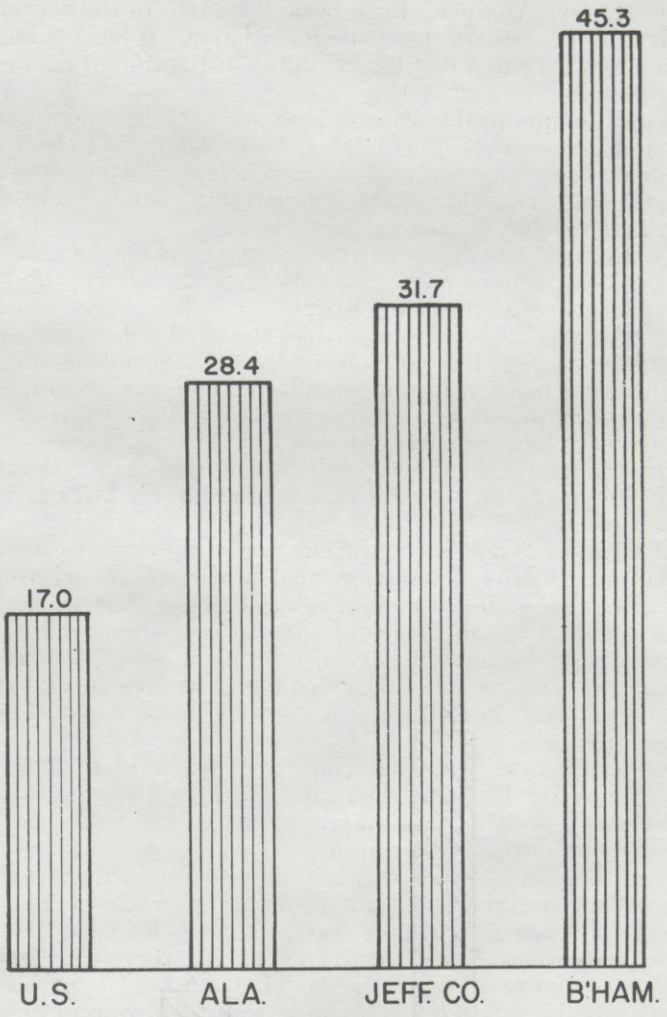
Fig. 3

TUBERCULOSIS

1971 NEW ACTIVE CASE RATES PER 100,000 POPULATION



Mr. ROGERS. Thank you.

As I get it, you are not getting any funds basically for TB?

Dr. HARDY. That is essentially correct. In our case we have been fortunate, this year only, in obtaining local funds. However, we have been told by our local appropriating bodies that this is a 1-year appropriation and come July we will be back at point zero again.

Mr. ROGERS. What about the support you are getting now for the other diseases? Is it sufficient for measles, for rubella, or gonorrhea?

Dr. HARDY. Again we have been fortunate in the support we have received in the past in these categorical areas. It has not been sufficient in gonorrhea. I think it will be with the institution of the new program that is coming the first of May.

In the communicable disease area we have had manpower, but we have not had vaccine. This is what I was referring to by fad funding. Suddenly the whole emphasis is on rubella and we tend to forget that measles, polio, tetanus, and whooping cough are still problems, particularly in the South.

Mr. ROGERS. Are there any other comments that we ought to know about? Do you have any criticisms of programs run by the Federal Government, or is everything fine?

Dr. HINMAN. I think we all feel the need for additional funding. I think, as George has said, one of the great problems we have had is the inconsistencies in funding levels and a 3-year program such as the current bill projects is a good start. But I think we really need commitments for longer terms than that.

Unfortunately the 3-year bill which this will continue did not receive any funding, essentially any funding, for 2 of the 3 years of its existence.

Mr. ROGERS. That is the difficulty, getting them to request the use of the bill. Because I am concerned in these types of programs that go across State lines, communicable diseases, that where you give a block grant, if the incidence of the disease is low, well, that State is going to say: "We don't have any problem here." Because they have so many other problems, they don't increase the block grant to take care of the continuing program. So they phase it out. That has been the experience.

Dr. REICHMAN. Mr. Chairman, if I may add to that. As was so well said by Dr. Hinman, the visibility of the disease is important. We say in New York City that the trouble is that tuberculosis at the present time does not have any sex appeal.

In talking to people, reporters and so forth, they say they don't believe there is tuberculosis, there is no tuberculosis. There is a phenomenal amount. The people don't realize it. Perhaps the Appropriations Committees don't realize it. That is where the hangup comes.

Your committee does realize it. That is why I appreciate a chance to tell you about it. This is the only way the program in my city and other cities at least will be able to survive.

Mr. ROGERS. We will see what we can do on a categorical basis.

Is there any truth that there is more evidence of cancer in Birmingham? Does it have a higher rate of cancer?

Dr. HARDY. First of all, I am not truly qualified to answer the question, but I think there is a greater emphasis in Birmingham in case detection than there is in the other parts of the State of Alabama because of our medical center. So we will see a higher reported incidence of disease in Birmingham than statewide.

Mr. ROGERS. What about respiratory problems?

Dr. HARDY. I think there is no question that we have a higher degree of respiratory problems.

Mr. ROGERS. Because of air pollution?

Dr. HARDY. Because of air pollution.

Mr. ROGERS. Has it improved lately?

Dr. HARDY. We are at a point now where control strategy plans are being submitted and reviewed. We have had excellent cooperation from industry. The only major corporation that has not yet submitted a plan—and the deadline is not passed yet—is United States Steel, which seems to be typical of their corporate stance nationally.

STATEMENT OF DR. M. LEON BAUMAN, PRESIDENT, U.S. CONFERENCE OF CITY HEALTH OFFICERS

Dr. BAUMAN. Thank you for the opportunity to appear before you. I have enjoyed listening to what the preceding people have said. Listening to this last panel I have enjoyed what these young people have said.

As they indicated, I will also indicate that it is the same story in every city across the country and in certain rural areas the same thing applies.

I am M. Leon Bauman, M.D., M.P.H., and I serve as director of the Wichita-Sedgwick Department of Community Health in Wichita, Kans. I am also the president of the U.S. Conference of City Health Officers affiliated with the U.S. Conference of Mayors. I am presenting this statement as president of the U.S. Conference of City Health Officers.

First of all, I want to express the appreciation of my organization for this opportunity to present testimony. Our organization urgently recommends the extension and expansion of the Communicable Disease Control Amendments of 1970. We hope that this committee will act expeditiously to approve the legislation that is required so that it can be signed into law and funded.

Let me take this opportunity to express for all the community services I represent a profound need of this legislation. Failure of the legislation should not occur because it will not be in the best interest of the health of the people of the communities of this Nation.

Community services have never been overfunded and these services are becoming increasingly important based on all observations made and statistics compiled. I think that has been illustrated again today.

VACCINATION ASSISTANCE

Attached to my testimony is appendix A (see p. 98), which documents the urgent need for the enactment of legislation to extend the communicable disease control amendments. You will note that approximately one-half of the children of low-income families between the ages of 1 and 4 years of age have not been vaccinated against measles, polio, or DPT. We are inviting an epidemic of these diseases with immunization levels so low. Those of us who work in metropolitan areas know that more needs to be done for the prevention of disease and disabilities from communicable disease and that control needs to be maintained by adequate funding on the national level through State and local community health departments.

VENEREAL DISEASES

Venereal diseases are epidemic in the United States at this time. They are a critical problem in cities with over 200,000 population. Attached also is appendix B (see p. 99) that sets forth the case rates for gonorrhea of 61 cities over 200,000 population. A study of appendix B will show that many of these cities are located in States that are represented by members of this committee. The incidence of syphilis in cities with a population of 200,000 or more is more than twice the case rate for the United States as a whole. The case rate according to size of cities is shown in appendix C (see p. 99) attached to my statement.

TUBERCULOSIS

Tuberculosis, despite an all too prevalent impression that it is a disease of the past, remains very much a serious health problem. And it is especially serious in the Nation's cities. Our city health departments have been adversely affected by the decisions of HEW which, as we can best understand it, was to the effect that since the proportions of the tuberculosis problem had been encouragingly diminished no further Federal support is needed. We hope the mistake that was made relative to VD will not be repeated with TB. It must be emphasized again and again that man has not yet eliminated any disease and that to ever do this, control must be maintained based on adequate funding. I want to make it clear that unless funds and efforts are directed to tuberculosis control we are going to lose any advantage we have gained.

It is contended by some that TB programs should be funded from 314(d) formula grants. We agree with the philosophy, but unfortunately the money hasn't followed the promise. Some members of this committee will recall that 2 or 3 years ago a Mr. Lewis, who was at that time the Deputy Administrator of HSMHA, appeared before this committee to oppose the enactment of the Communicable Disease Act. His superior was a Dr. Joseph T. English, who on March 28, 1972, had this to say relative to the cessation of TB project grants to New York City:

> It is clear to me that too much of the support which the present administration is providing to comprehensive health efforts is being done at the expense of still necessary categorical programs—programs which have proven themselves to be dramatically effective over the years. This is nothing but a shameful shell game.

Continued support of proven programs together with comprehensive health efforts must be guaranteed. New money is absolutely essential and any effort to obscure this fact, any effort to sacrifice one critically valuable program to develop another is both deceitful and damaging to our citizens.

The U.S. Conference of City Health Officers is also most interested in the provisions of the legislation that would authorize funds for health education activities. We know that an important aspect of health protection is the education of parents as to the importance of immunization protection as well as the education of individuals with respect to venereal disease and tuberculosis. Every director of a city department of community health knows from personal observation all the facts stressed in this legislation. Therefore, we strongly urge the enactment of the legislation and we hope that the membership of this committee as well as the Congress will recognize the importance of securing funds toward the implementation and maintenance of these programs.

Again, I welcome the opportunity to appear before you to make this statement.

(Appendixes referred to follow:)

APPENDIX A

U.S. IMMUNIZATION SURVEY—1970–71

[In percent of population]

Age group	1970	1971
History of measles vaccine:		
1 to 4	57.2	61.0
5 to 9	62.8	69.7
History of rubella vaccine:		
1 to 4	37.2	51.2
5 to 9	46.5	63.2
1 to 4 years of age, receiving specified doses of polio vaccine:		
3 plus OPV and/or 3 plus IPV	65.9	67.3
No doses	10.8	8.6
1 to 4 years of age, receiving specified doses of diphtheria-tetanus-pertussis vaccine:		
3 plus doses	76.1	78.7
No doses	7.0	5.8
1 to 4 years of age, in poverty areas within central cities less than 250,000 receiving specified vaccines:		
Measles	41.4	48.7
Polio (3 plus OPV and/or 3 plus IPV)	50.9	54.3
DTP (3 plus doses)	55.8	58.4

APPENDIX B

GONORRHEA—CITIES OVER 200,000, FISCAL YEAR 1971

Rank	City	Cases	Rates
1	Atlanta	15,790	2,510.3
2	San Francisco	14,592	2,066.9
3	Charlotte	4,175	1,557.8
4	Memphis	11,293	1,540.7
5	District of Columbia	11,197	1,515.2
6	Norfolk	4,059	1,357.5
7	Newark	5,299	1,355.2
8	Richmond	2,981	1,348.9
9	Baltimore	11,112	1,237.4
10	Cleveland	9,854	1,230.2
11	Dallas	14,761	1,145.2
12	Chicago	39,354	1,122.5
13	Kansas City	6,032	1,112.9
14	St. Louis	6,715	997.8
15	Portland	3,578	934.2
16	Syracuse	1,940	919.4
17	Akron	2,733	908.0
18	Milwaukee	6,282	835.4
19	Houston	13,759	827.4
20	Boston	4,913	827.1
21	Tampa	4,017	821.5
22	Dayton	2,158	793.4
23	New Orleans	4,715	727.6
24	Des Moines	1,492	717.3
25	Columbus, Ohio	4,082	713.6
26	Omaha	2,617	694.2
27	Denver	3,202	637.8
28	Fort Worth	4,141	625.5
29	Los Angeles	39,987	566.7
30	Birmingham	3,685	546.7
31	Jacksonville	2,864	541.4
32	Detroit	8,473	536.9
33	Philadelphia	10,946	536.3
34	Oklahoma City	2,608	518.5
35	Indianapolis	3,866	495.6
36	Oakland	4,518	472.6
37	Mobile	1,596	456.0
38	New York City	36,562	452.5
39	Seattle	5,010	451.4
40	Louisville	3,069	443.5
41	Wichita	1,591	440.7
42	Rochester	2,838	411.3
43	Cincinnati	1,987	397.4
44	St. Paul	1,254	394.3
45	Toledo	1,515	385.5
46	Albuquerque	1,212	371.8
47	Providence	626	357.7
48	Miami	4,077	342.9
49	San Diego	4,396	328.8
50	San Jose	3,330	319.9
51	Phoenix	2,675	293.6
52	El Paso	1,022	277.0
53	Honolulu	1,001	270.5
54	Tulsa	1,016	257.2
55	Minneapolis	2,107	228.3
56	Tucson	752	222.5
57	Buffalo	2,383	216.8
58	Jersey City	576	216.5
59	San Juan	1,684	210.8
60	San Antonio	1,551	184.4
61	Pittsburgh	2,596	162.3

APPENDIX C

PRIMARY AND SECONDARY SYPHILIS, URBAN-RURAL DISTRIBUTION, UNITED STATES, CALENDAR YEAR 1970

Population of city	Cases	Rate per 100,000
Over 200,000	13,891	24.5
50,000 to 20,000	3,445	10.3
Smaller towns and rural areas	4,646	4.1
Total	21,982	10.8

Mr. ROGERS. Thank you, Dr. Bauman. The facts you have given us are most helpful. Do you feel the doctors in your area or the areas that you have seen in your organization promptly and adequately report communicable disease cases?

Dr. BAUMAN. It so happens in our specific area we did a study on syphilis several years ago. I think we get the major part of syphilis reported. We figure 96 percent of the cases were reported. We actually visited the doctors, had a team visit the doctors and talk to them about it.

Mr. ROGERS. I see. Rather than just letting them send in their reports?

Dr. BAUMAN. Yes. Most of them have a serologic done in our laboratory.

Mr. ROGERS. And on gonorrhea?

Dr. BAUMAN. No, it does not come close.

Mr. ROGERS. Should they not have to report the number of cases?

Dr. BAUMAN. If we knew what was happening. We have developed a technique, a kind of survey technique. When nonreportable diseases are indicated, we call them and ask them what they are seeing and ask them how many they are seeing, which helps us some. We all need better records as to what is actually happening.

Mr. ROGERS. Why would it not be just as well to have a requirement of law that these types of cases be reported to public health authorities?

Dr. HARDY. Mr. Rogers, if I may, first of all the reporting of venereal disease and tuberculosis should not be by number, but by name. In this case something can be done; in fact, it is the only way the transmission of the disease can be stopped.

I would disagree with earlier comments of the committee today that only numbers are necessary. I think the completeness of a case report depends entirely on the disease and whether something can be done beneficially for the patient and the community. With venereal disease reporting, names are necessary.

Mr. ROGERS. If the doctor himself is treating the case——

Dr. HARDY. It is the contacts that are important to break the chain of transmission.

Dr. BAUMAN. I for many years have felt they should be reported by name. I think it is again a shell game if they don't report them by name. We get the reports by name, those that we get.

Mr. ROGERS. Do you get them by name?

Dr. HARDY. Yes, sir, we do. I would say again it depends on the disease. One of the reasons physicians have been reluctant or have stopped reporting communicable diseases is because they could see no benefits from it. Almost all of the States require reporting of communicable diseases. If you saw the list of diseases physicians are supposed to report and you were a busy practitioner, you would say the heck with it, too. If reporting is limited to those diseases for which something can be done—in other words, if a physician knows he reports a case of measles and everybody else in the community is going to report measles—then the local health department will know early that there is an epidemic building up and will act swiftly to stop its occurrence, then, hopefully the physician might report.

The fact of the matter is, in years past physicians would report diseases and the report would come out in an annual summary from the local health department. Reporting had no effect.

Mr. ROGERS. That is the department of health's responsibility, isn't it?

Dr. HARDY. Yes, sir.

Mr. ROGERS. Local health officers.

Dr. HARDY. Exactly. I think this is where public health has fallen down. This plus the tremendous number of reportable diseases. I would not support putting in some kind of civil penalty. I don't know how you could enforce it to begin with.

The question was asked by Dr. Carter today of Dr. Sencer, had Dr. Sencer seen any chancres? You can still see the chancre and know that it is a venereal disease; however, if it is the doctor's friend, he may not report it. He can say, "I don't think that is a venereal disease." Who could prove otherwise?

Mr. ROGERS. If we let it go like that, we never will have it. I don't see why we can't have a requirement for the reporting of these diseases which are highly communicable. If we report it and there is an indication of an epidemic, it could quickly be caught and action taken. If not, then we ought to have some kind of penalty if they don't report so that we can take action.

Now on syphilis or gonorrhea, I think it is very important and for the very purpose that you say. Some friend comes in, they don't want to report him. That makes how many other people susceptible to the disease? There is no telling how many.

It is all the more important to have a compulsion on the doctor that when his friend comes in, he says, "I have by law to report this."

Dr. HARDY. Communicable disease reporting is broken down into categories. There are currently four diseases for which reporting is required by international law—plague, smallpox, yellow fever and cholera. Then we pass down in varying degrees of severity through tuberculosis and venereal disease.

Mr. ROGERS. Yellow fever is not a problem for us here. Cholera is not a problem for us here. Smallpox is no longer a problem. So the law must be adjusted to what our problems are.

Our problems are gonorrhea and syphilis and measles. We are not getting any reporting properly.

Dr. HARDY. I can't deny that.

Mr. ROGERS. That is the evidence. I want to act on the evidence.

Dr. BAUMAN. In our shop syphilis is well reported.

Mr. ROGERS. But others say it is not.

Dr. BAUMAN. But it is not in other places. This is a special project we took on.

Mr. ROGERS. This is great. You have done good work on that. But gonorrhea is not, in your area?

Dr. BAUMAN. It must be reported by name to do any good. There is no use reporting numbers.

Mr. ROGERS. Numbers would help give us some idea. I agree, to do something, you have to have names.

Dr. BAUMAN. You have to get back to the people who have the disease.

Mr. ROGERS. A lot of it can probably be the fact that maybe we have not made it a requirement of public health doctors to get out and visit the doctors as you have done and find out what is going on and do it.

Dr. BAUMAN. I am not necessarily defending my breed of cats at the moment, but I think most of them do a pretty decent job on this kind of thing.

Mr. ROGERS. I know they try.

Dr. BAUMAN. We are short of staff, we are short of a lot of other things. We don't get the money to hire the staff to do the job that you talk about here.

Mr. ROGERS. I agree. That is why we are going to try to help you in this bill.

Dr. BAUMAN. We need that one, yes.

Mr. ROGERS. I think these points you have brought up have been very helpful to us. We are very grateful to you and your organization for being willing to appear.

Dr. BAUMAN. It was a privilege of ours. Thank you.

Mr. ROGERS. Thank you, Doctor.

Our last witness is Mr. Charles R. Kiesewetter, executive director of the Committee on Cooperation with Federal Agencies of the National Tuberculosis and Respiratory Disease Association.

We welcome you to the committee and also appreciate your patience.

STATEMENT OF CHARLES R. KIESEWETTER, IN BEHALF OF NATIONAL TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION

Mr. KIESEWETTER. I am Charles R. Kiesewetter, executive director of the Tuberculosis and Health Society in Detroit, Mich. I am here to present the position of the National Tuberculosis and Respiratory Disease Association on H.R. 14030 and H.R. 14455.

With your permission, in an effort to save time, I have filed our written statement with the clerk of the committee. I will orally only touch upon the highlights of our testimony.

We urge the extension of the Communicable Disease Act. We are particularly pleased to see in H.R. 14455 a specific authorization of funds for tuberculosis control. The reasons for special earmarking are, I am sure, quite clear to you. The present situation under Public Law 91–464 with no separate authorization has resulted in no funds being appropriated for tuberculosis control in fiscal 1972. For the first time in decades there are no funds being designated at the Federal level solely for the support of tuberculosis control.

I am reminded of our testimony before this committee on March 13, 1970, during your hearings on the original Communicable Disease Act. At that time Dr. Robert Anderson, managing director of the National Tuberculosis and Respiratory Disease Association, who presented our testimony, expressed real concern and accurately predicted that Federal support for tuberculosis programs would be curtailed, if they were solely dependent upon either 314(e) or 314(d).

Furthermore, he pointed out the importance of establishing a separate authorization for tuberculosis. As a result of the recent curtailment, and finally in 1972, the abolishment of Federal funds for TB

control, many of our vital programs in the large cities and other high incidence areas of our country are in serious jeopardy.

In my judgment, the situation in my home community of Detroit is typical of the problems facing the rest of the country. Large cities reported an overall rate of 47 new active cases per 100,000 population as compared with, as you recall, the national average of 18. We have many census tracts in our inner city with case rates as high as 135.

Over the past 8 years Federal funds in the amount of $2.2 million have been awarded to intensify Detroit's efforts in tuberculosis control. This amount, while only 3 percent of the total expenditure in our community of $69 million, has enabled us to implement new, modern TB control practices.

Our objective has been to effect a transition from a sanatorium system of medical care, to an emphasis on the utilization of outpatient clinics and general hospitals in order to bring TB into the mainstream of our medical care system.

The successful implementation of this innovative approach is being achieved in Detroit. The number of days of patient hospitalization in 1967 was 354,907; this was reduced dramatically in 1971 to approximately 61,000. This represents a reduction of 83 percent. During this same time period new active cases reported have remained relatively stable.

I have with me our 1971 annual report, which will reflect our situation in Detroit, and which I would like to file with the committee.

Mr. ROGERS. We will be glad to have it for the files.[1]

Mr. KIESEWETTER. What I am trying to emphasize is that the Federal support for TB control in Detroit and other communities throughout the United States has enabled us to implement these new, proven successful modern concepts.

The flexibility of these funds, I think, has been most important. Without this Federal support we are already witnessing cutbacks in vital activities. This, I remind you, is at a point in time when any reduction in our efforts will, in my judgment, prove to be a most costly decision in the long run—both in terms of unnecessary human suffering and eventually in a requirement for new and more tax dollars to again catch up.

In our statement we have furnished you with current statistics on the problem of tuberculosis. I would particularly like to call to your attention the fact that although case rates in tuberculosis are higher in large cities, more than half of all new cases reported are from areas of less than 100,000 population. This dramatically points out that no one is safe from exposure to a communicable disease in our mobile population until all communities have tuberculosis under control.

In conclusion, the National Tuberculosis and Respiratory Disease Association considers extension of the Communicable Disease Act essential to a responsible national public health policy.

We thank the committee for the opportunity to present our testimony in support of this important legislation.

(Mr. Kiesewetter's prepared statement follows:)

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[1] 1971 annual report of the Office of Respiratory Disease Control, Detroit and Wayne County Department of Health, based on reported cases for the year Jan. 1–Dec. 31, 1970.

STATEMENT OF CHARLES R. KIESEWETTER, EXECUTIVE DIRECTOR, TB AND HEALTH SOCIETY OF WAYNE COUNTY, DETROIT, MICH., IN BEHALF OF NATIONAL TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION

The National Tuberculosis and Respiratory Disease Association urges the extension of the Communicable Disease Act. Passed in 1970 to remedy what had become a critical situation in communicable disease control, the need for this authority is no less urgent today than it was two years ago.

TB FUNDING UNDER THE ACT

We are very pleased to see that H.R. 14455 provides a solution to the grave situation which has arisen in relation to funding of tuberculosis control under P.L. 91–464. A separate authorization will make TB control less dependent on the interests of the appropriations committees and the Administration.

In fiscal 1972 no funds were specified by the appropriations committees for TB control. None of the $4 million whose use was left unspecified was allocated by the Department of Health, Education and Welfare to TB control. For the first time in decades there are no funds designated at the Federal level solely for support of TB programs.

The effects are being felt throughout the country. Many states and cities simply cannot find the necessary funds to maintain adequate tuberculosis control programs.

Support for TB control from 314(e) project grants of the Comprehensive Health Program was discontinued in fiscal 1970 by the Department of HEW. It was because of that crisis that P.L. 91–464 received such overwhelming support by communicable disease authorities. Although DHEW suggests that adequate support for TB control can be obtained from 314(d) formula grants, that assumption is unrealistic. The increase in 314(d) formula funds has been minimal and the demands on this money heavy. The TB control programs which have managed to obtain some 314(d) money will find it difficult to retain those funds.

THE NATURE OF TB CONTROL

Control programs for tuberculosis and venereal disease are continuous operations and as such need sustained support. They use similar management techniques. These techniques are different from the methods used for controlling other communicable diseases in which only a vaccination is necessary.

The tracing of contacts of cases is basic to success in both programs—it is here that case finding is most productive. Contacts must not only be found, often a difficult enough job, but in the case of TB, they must be persuaded to continue taking drugs over a long period of time.

This kind of activity demands trained staff—investigators, records clerks, medical personnel. It is not the type of operation one puts together overnight. A substandard program can portend an upsurge in cases. TB and VD control need as much assurance of support for their ongoing operations as it is possible for this Act to provide.

DISEASE PREVENTION

There is much rhetoric in public health circles today about the need for preventive health services, in order to reduce the spiralling costs of medical care—obviously a worthwhile objective. However, the potential for preventing many diseases is limited. The disease programs in which we reap the most certain reward for our efforts are those dealing with communicable diseases. We know how to prevent communicable diseases and how to treat them successfully.

With the discovery of anti-tuberculosis drugs two decades ago, the treatment of TB was revolutionized. Today it is rare for a patient to have more than a short hospital stay. Patients become non-infectious in a short period of time although they must take medication over a period of 18–24 months to ensure complete arrest of the disease process. They must remain under medical supervision of clinics or private physicians during this period. Obviously, this outpatient care drastically reduces the cost of TB control in these days of skyrocketing hospital charges.

Unhappily, this optimistic picture does not tell the whole story. Patients must be found in order to be treated and before they have the chance to infect others. If allowed to go untreated, TB patients have as much risk of dying as did those of previous generations; the infant who becomes infected with the TB bacillus

will certainly succumb to death from meningitis or widespread tuberculosis. Thus the availability of effective drug therapy makes it even more of a tragedy when TB control programs are cut back.

THE TB PROBLEM

In 1971 there were more than 35,000 *new* active cases of TB reported in the United States—hardly a vanishing disease. A disturbing note is the fact that for the first time in recent years the decline in nonwhite cases appears to have come to a halt. Although rates are highest in large cities, more than half of all cases are reported from areas of less than 100,000 population. A chain of high rate counties extends down the eastern seaboard and along the Mexican border; a similar band of counties stretches throughout the Appalachian region from the Virginias to the Gulf.

Today TB is a disease which lingers on mainly among the poor. Poor people, whether living in rural or urban areas, are the ones least apt to have private medical attention and hence to discover that they have the disease.

A significant factor which cannot be ignored in assessing the needs in TB control in the years ahead is the possible influence of the change in our immigration quotas. Proportionately more persons are coming into the United States from countries with higher prevalence of infection with the TB bacillus. Although these persons are examined on entry for presence of active TB, the rate at which they may break down with TB cannot be foreseen.

About three-fourths of the new active TB cases in Hawaii in recent years are among immigrants, many of them from the Philippines; a quarter of these cases develop at least five years after the immigrant arrives.

None of us is safe from exposure to communicable disease. Persons living in high prevalence areas often work in other areas. Our mobility is a national characteristic.

CONCLUSION

The Communicable Diesase Act assures a continuity of support not possible under the Comprehensive Health Program. Our organization considers extension of the Act essential to a responsible national public health policy.

The addition of separate authorization for TB in H.R. 14455 will assure that control funds for that major disease will not be overlooked. We also approve the addition of funds for public education. These funds could be very helpful in times of large immunization campaigns.

We thank the Committee for the chance to present our reasons for supporting this important legislation.

Mr. ROGERS. Thank you for being here and giving us these facts. I think the record clearly shows the need for this type of legislation. I am very hopeful the committee can act very rapidly to bring this into realization.

We are grateful to everyone who has been present to give testimony. I feel sure the committee will act favorably.

This concludes the hearing.

(The following letters were received for the record:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., May 8, 1972.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: Legislation pending before the Subcommittee on Public Health and Environment, H.R. 14455, would amend the Public Health Service Act to extend and revise the program of assistance for the control and prevention of communicable disease. We consider this legislation to be extreme importance to the health of the American people.

The communicable disease control program contemplated by this legislation would be against tuberculosis, venereal disease, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, whooping cough, and other communicable dis-

eases amenable to reduction and determined by the Secretary to be of national significance.

The spread of infectious venereal disease has already reached epidemic proportions. Statistics developed by the Department of Health, Education, and Welfare reveal that gonorrhea has become the number one reported communicable disease with syphills being fourth. We are pleased, therefore, to note the special emphasis which the legislation places on venereal disease control programs.

The progress which has been made in the eradication of communicable diseases in the United States is due, to a great extent, to the impetus which has been given to state and local programs by the Communicable Disease Control Act and its predecessors. It is clear to us that a great deal still can and should be done to bring communicable disease under further control. We would urge your Subcommittee's support of this constructive and important continuation of the Communicable Disease Program.

Thank you for permitting us this opportunity to offer to you our support of H.R. 14455. We respectfully request that our remarks be included in the record of your hearings on this legislation.

Sincerely,

ERNEST B. HOWARD, M.D.,
Executive Vice President.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., May 3, 1972.

Congressman PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR MR. ROGERS: The American Nurses' Association, the professional association of registered nurses in the United States, would like to indicate to you its support of your bill, H.R. 14455, to amend the Public Health Service Act to extend and revise the program of assistance under that Act for the control and prevention of communicable diseases.

The Association commends you on your efforts to extend and enlarge upon already existing legislation which would authorize needed federal grants for vaccination programs and other communicable disease control programs.

The Association especially supports the section of H.R. 14455 which addresses itself to conducting the necessary programs needed to develop an awareness in those persons in an area (who are most susceptible to one and/or several communicable diseases) of the importance of immunization against such diseases, to encourage such persons to seek appropriate immunization, and to facilitate access by such persons to immunization services. Public health nurses are and have long been involved in case-finding, as well as in referral for diagnosis and treatment, and in prevention.

I respectfully request that this letter be included in the record of your hearings on H.R. 14455.

Sincerely,

EILEEN M. JACOBI, R.N., ED.D.,
Executive Director.

(Whereupon, at 4:10 p.m. the subcommittee adjourned.)

APPENDIX

Report of the National Commission on Venereal Disease to the Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare

Why a National Commission on Venereal Disease

The venereal diseases, syphilis and gonorrhea, have reached epidemic proportions throughout the United States. Reported cases of gonorrhea have been increasing yearly at an alarming rate of 10–15 percent and in fiscal year 1970 increased by 79,000 cases to reach an all-time high of 573,000. After four years of decline, reported infectious syphilis increased by 1500 cases in fiscal year 1970.

Recent studies of reporting practices by private physicians made for the Center for Disease Control by the American Social Health Association and the American Medical Association revealed that private physicians report only 18.7 percent of the cases of primary and secondary syphilis which they diagnose and treat and only 16.9 percent of the cases of gonorrhea they treat.

These facts and other data considered, it is estimated that 80,000 cases of infectious syphilis and 2.2 million cases of gonorrhea occurred last year.

Private medicine evidently plays a vital role in venereal disease control since practicing physicians treat 80 percent of the cases.

Therefore, the Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, deemed it advisable to convene a body of knowledgeable and concerned physicians from national health organizations and national medical specialty groups to study the problems, to consider ways to bring about a reversal of these trends, and to make recommendations for control to him and to the professional groups which the Commission members represent.

The Charge to the Commission

The mission assigned to the National Commission on Venereal Disease was to: (1) outline ways to improve among medical students and practicing physicians the knowledge of clinical management of and public responsibility for venereal diseases; (2) devise ways to increase the understanding among private physicians of the venereal disease problem and to bring public health and private medicine into a closer working relationship; (3) identify broad and specific areas of venereal disease research needs; and (4) make recommendations for implementing a program to reduce the incidence of venereal disease.

The Commission, consisting of a Chairman and 16 members, met for the first time in Washington, D.C., on April 19 and 20, 1971.

National Commission on Venereal Disease,
New York, N.Y., February 1, 1972.

Dr. Merlin K. DuVal,
Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, Washington, D.C.

Dear Dr. DuVal: As Chairman of the National Commission on the Venereal Diseases, established by your predecessor Dr. Roger Egeberg in February, 1971, I should like to submit the attached report.

This National Commission has had wide representation from both private medicine and public health. We have called heavily for consultant advice on many experts including the staff of the Center for Disease Control. Valuable assistance was rendered to the Commission by the Traveling Seminar of the World Health Organization. This committee of venereal disease experts from various parts of the world toured and studied the facilities in the United States

during the month of October, 1971. The opinion of this expert group has been of inestimable value to the Commission.

Viewed in the perspective of 65 years since the discovery of the etiological agent of syphilis, much has been learned about the venereal diseases through experimentation, clinical observation and epidemiological research. Yet, despite potent additions to our therapeutic weapons, both syphilis and gonorrhea continue at high levels in every country in the world including the United States, and there is evidence that the incidence of both diseases is rising. Existing measures of control, while doubtless valuable, are of limited effectiveness; clearly new tools are needed. Such tools will not just emerge but must be fashioned out of the results of research. The Commission has attempted to make recommendations concerning microbiological, immunological, clinical, epidemiological and behavioural research.

We have attempted to examine the reasons why the present methods of control have proven inadequate. Among these is the failure of mass education of the general public, including venereal disease education in the schools. Failure of our medical schools to train outgoing physicians in the clinical and public health aspects of venereal disease control is a major factor. The scarcity and inadequacy of present treatment facilities are discussed. The laws concerning venereal disease control are reviewed. The problem of liaison between private medicine and public health has been studied. Lastly, recommendations are made for the funding of an overall comprehensive program, aimed at the eventual control of these diseases in the United States.

It has been repeatedly stressed by members of the Commission that while new methods of control are being explored and developed, present methods must be continued and augmented.

It has been a pleasure and rare privilege to work with such a distinguished group of physicians as those comprising this commission. They have given unstintingly of their time and expert knowledge. We sincerely hope that our work will be of real assistance to you in helping to shape the future of venereal disease control in the United States and the world at large.

Sincerely yours,

BRUCE WEBSTER, M.D.,
Chairman.

FOREWORD

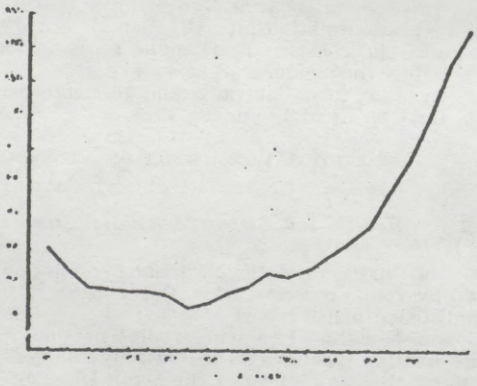
The Commission is deeply concerned over a number of findings:

(1) the alarming increase of reported venereal disease;

The Commission noted that reported cases of gonorrhea, following a decline in the early 1950's, has shown a steady rise from 216,476 cases in fiscal year 1957 to an all time high of 624,371 cases in fiscal year 1971.

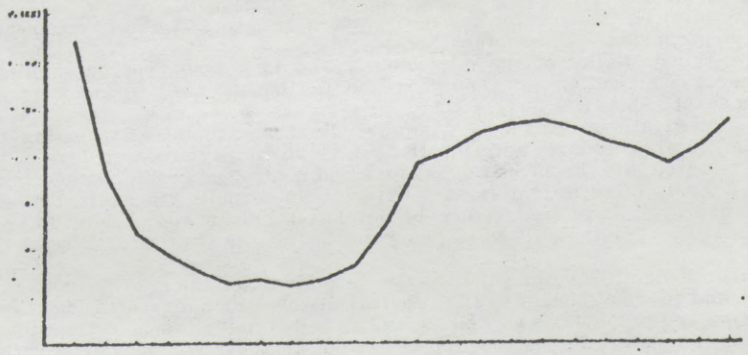
GONORRHEA

Reported Cases, United States, 1950-1971



The 23,336 persons reported with infectious syphilis in fiscal year 1971 was the greatest number of cases reported in any year since 1950.

PRIMARY AND SECONDARY SYPHILLIS
Reported Cases, United States, 1950-1971



The Commission examined the most recent data of all reportable communicable diseases and found that of the total of 1,498,669 reported cases of specified notifiable diseases in calendar year 1970, gonorrhea constituted 600,072 and syphilis 91,382 [see bar chart in Appendix III].

(2) the woefully inadequate efforts devoted to venereal disease research, basic, clinical, epidemiological, methodological and behavioral;

(3) inadequate venereal disease educational programs for the public and professional education for the physician;

(4) the failure of practicing physicians to report to health authorities all cases of venereal disease they diagnose and treat;

(5) the failure to apply, on a national basis, known effective venereal disease control measures; and

(6) the insufficient federal funding of all venereal disease control activities.

The Commission reviewed a mass of data, consulted investigators, private physicians and health officials, interviewed private citizens from many areas of the country and convened in work groups and as a body a number of times before completing its deliberations. The many different backgrounds and competencies of the Commission members brought a variety of judgments to bear on the problem.

The Commission is indebted to Dr. Richard M. Krause, Professor of Microbiology, Department of Microbiology, Rockefeller University, New York, New York; Dr. James E. Elias, Assistant to the President, The Adolph's Foundation, Burbank, California (Ph.D., Sociology); and Dr. John C. Cutler, Director of the Population Division and Professor of International Health, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania, who provided consultation in their areas of expertise in helping the Commission formulate its recommendations.

The Commission extends thanks to Dr. David J. Sencer, Assistant Surgeon General and Director, Center for Disease Control, for his assistance during its organization and deliberations.

The Commission is most grateful for the assistance, cooperation and excellent staff work of William J. Brown, M.D., Principal Staff Assistant to the Commission and former Chief, Mrs. Marilyn Gable, Secretary to the Chief, and many other members of the Venereal Disease Branch of the Center for Disease Control.

Principal Recommendations

This section sets forth, in brief form, what are considered to be the major recommendations by the Commission. For a more detailed exposition of these and other recommendations, please refer to the following section, Recommendations and Comments.

The National Commission on Venereal Disease recommends that:

(1) an enlarged nucleus of capable scientists, both inside and outside the Department of Health, Education, and Welfare be recruited for active engagement in venereal disease research;

(2) studies be vigorously pursued for the development of vaccines for syphilis and gonorrhea, it being fully realized that few infectious diseases have been brought under effective control without suitable vaccines;

(3) studies be pursued for the development of safe and effective topical or systemic prophylaxis for venereal diseases;

(4) detailed studies of the microbiology and immunology of uncomplicated gonorrhea, complications of gonorrhea and the pathogenesis of gonococcal infection be intensified;

(5) investigations designed to improve diagnostic methods, including both immunological procedures and culture be more vigorously prosecuted;

(6) research into the effectiveness of current control programs be undertaken;

(7) a group of investigators with expertise in sexually transmitted diseases other than syphilis and gonorrhea be developed and an appropriate unit with responsibilities for these diseases be established at the Center for Disease Control;

(8) the Federal Government increase its support for the study of human behavior and its relationship to the venereal diseases including attitudes toward education and prophylaxis as well as studies to determine to what extent present methods of venereal disease case reporting and contact tracing may deter patients from seeking treatment and discourage physicians from cooperating;

(9) an advisory council on venereal diseases with appropriate governmental and nongovernmental membership be established to make recommendations to the Assistant Secretary for Health and Scientific Affairs of the Department of Health, Education, and Welfare for the implementation of the research and control programs designed to reduce the incidence of the venereal diseases;

(10) strenuous efforts be made to reinstitute the teaching of venereology in medical schools and that this teaching be subsidized in each school by a federal grant of $20,000–30,000 per year;

(11) schools of public health be urged to include subject matter relating to venereal diseases and their control and that a faculty position be supported in whole or in part by a federal grant in the amount of $20,000–30,000 per year;

(12) education about the venereal diseases be introduced in the curriculum of public, parochial and private schools no later than in the seventh grade as a part of a basic education in health sciences;

(13) the Federal Government initiate and support a program of public education and information about the venereal diseases similar to that of the National Clearinghouse on Smoking and Health;

(14) the Federal Government make changes in existing laws and regulations which (a) would authorize, as under Public Law 91–623, the Department of Health, Education, and Welfare to assign commissioned officers to State and local areas for venereal disease control activities; (b) require that all health care facilities, which provide general medical services or more limited health care services, make available diagnostic testing for the venereal diseases and treatment for these diseases to those patients found to be infected if the programs are to be considered eligible for federal sponsorship; and (c) require that, in order to be eligible for federal support, facilities or programs which provide treatment for venereal disease patients use adequate treatment schedules which have been demonstrated to be economical, safe and effective;

(15) federal, State and local governments make a strenuous effort to improve the organization and management of venereal disease clinics, to upgrade the quality of care rendered in these clinics and to provide facilities which allow a maintenance of reasonable standards of privacy and dignity for patients;

(16) medical specialty groups establish standing committees on the venereal diseases with mechanisms for communication among and joint action by these committees;

(17) each State and, where appropriate, local governments, establish permanent commissions or similar advisory groups with representation from medical and other professional health groups, legislative bodies and the general public to advise the responsible health officials on their venereal disease control program; and State and appropriate local medical societies establish standing committees with similar responsibilities and that special emphasis be placed on attempts to promote the reporting of venereal diseases by practicing physicians and to encourage epidemiological followup;

(18) to reduce the incidence of venereal disease, known control techniques, including casefinding and public education, be fully employed on a nationwide basis, and such programs be funded primarily through federal project grants;

(19) for all elements of the venereal disease control efforts, the Federal Government appropriate and expend through the Department of Health, Education,

and Welfare in fiscal year 1973 a total of $46,150,000, this sum increasing to $68,035,000 in fiscal year 1977.

RECOMMENDED DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE FUNDING LEVELS—ALL VENEREAL DISEASE PROGRAM AREAS

[In thousands of dollars]

	Fiscal year—					
	1972	1973	1974	1975	1976	1977
Project grants to States	22,300	25,000	28,000	30,000	30,000	30,000
Venereal disease branch operating funds	5,930	10,450	11,075	11,750	12,500	13,300
Professional education		4,200	4,485	4,700	4,920	5,235
Venereal disease research (new)		6,500	11,250	14,100	19,500	19,500
Grand total	28,230	46,150	54,810	60,550	66,920	68,035

Recommendations and Comments

Earlier in this report the Commission has expressed its deep concern over the alarming increase of reported venereal disease; however, it is not surprising that the venereal diseases have once again reached epidemic proportions in the United States. Control efforts directed against these diseases have perforce been based upon early casefinding and treatment of those persons infected. In theory, it would be possible to eliminate syphilis and gonorrhea if each infected individual could be identified and rendered noninfectious through treatment before there was an opportunity to pass the disease on to another. Although it is impossible to achieve this ideal, it has been demonstrated that intensive control efforts can, indeed, slow down the rate of spread of these diseases. However, such programs must involve a concerted, nationwide effort and require the establishment of an extensive organization dedicated to this work. Such a program is expensive and as it begins to achieve success, the problem becomes less acute and the public, the health officials with general responsibilities, and the executive and legislative branches of government are increasingly less concerned about venereal disease. Understandably, it becomes more difficult for these groups to feel justified in allocating resources to venereal disease control when other competing demands begin to assume relatively greater significance. At this point, the individuals with primary responsibility and concern for control of the venereal diseases, the venereal disease control officials at federal, State and local levels and voluntary organizations such as the American Social Health Association, suddenly become "special interest groups" with a narrow, unrealistic outlook. This attitude is followed by gradually decreasing financial support of the program and a dismantling of the control organization. The inevitable occurs. The rate of transmission increases until once again there is a clamor for renewed control efforts. This cyclic phenomenon will appear familiar not only to workers in other health programs but in many other fields.

Despite this seemingly unavoidable sequence of events, the Commission strongly feels it is essential that we move forward once again as a nation with an intensified, large-scale attack on these diseases utilizing all elements of our available armamentarium. However, if the wheel is not to turn once more, there must be greater and sustained dedication of funds and talents to the development of new knowledge which will provide more permanent solutions to the venereal disease problem. It is in recognition of the foregoing that the following recommendations and comments are made.

Measures to Reduce the Incidence of Venereal Disease

A. Application of known control techniques

The National Commission on Venereal Disease Recommends:

1. That, while new control measures are being developed, every effort be made to employ fully, presently known techniques on a nation-wide basis and such programs be financed primarily through federal project grants based on the extent of the venereal disease problem in each State with recognition of changing geographic patterns of disease incidence which occur after control programs are initiated.

Comment

The weight of the recommendations of the Commission bear on new steps which must be taken now if the history of fluctuating trends in venereal disease is not to be repeated forever. Since the pay-off in reduced incidence from these recommendations will not be realized immediately, however, it is imperative that existing procedures be fully employed. They include the rapid identification and treatment of contacts to infectious cases, routine testing of individuals known to be at high risk for the disease, and educational programs designed to inform persons at risk about the disease and to prompt them to volunteer for examination early.

Since these diseases are rapidly transmitted, and since people move with increasing frequency among cities and States, it is essential that these case detection and prevention devices be applied consistently on a national basis. At the presnet time, States and localities are primarily responsible for the diagnosis and treatment of people with veneral disease, with federal grant support used to supplement their efforts to maintain casefinding and surveillance capabilities. This arrangement recognizes the essential partnership nature of the control effort. Although States and localities should retain the primary responsibility for venereal disease control, the fact that the spread of disease respects no political boundaries makes it a national problem. Intensive casefinding and treatment of individuals in one State does not protect the population of that State from the constant reintroduction of disease. In discharging its responsibility for protecting the population from the interstate and international spread of venereal disease, the Federal Government cannot rely on quarantine. Instead, coordinated control procedures of the type described above must be relied upon in the discharge of this federal responsibility. It is important to note, moreover, that increases in venereal diseases have almost always coincided with a weakening of federal commitment to their control.

B. RESEARCH

The National Commission on Venereal Disease recommends:

1. That an enlarged nucleus of capable scientists, both inside and outside the Federal Government, be recruited for active pursuit of venereal disease research and a central communication and coordination point be established.

Comment

The Commission finds that only a handful of scientists in the United States—indeed in the world—are presently engaged in microbiological and immunological research on syphilis and gonorrhea, and even fewer are carrying out investigations on other venereal diseases. As senior investigators from earlier decades have retired from active research, the shortage of scientists has become critical. Although recent National Institutes of Health efforts to augment extramural funds for venereal disease research may persuade scientists from other fields to take up an interest in venereal disease research, specific efforts must be made to attract and maintain a larger nucleus of scientists who have a long-term commitment to venereal disease.

2(a). That studies be vigorously pursued for the development of vaccines for syphilis and gonorrhea, it being fully recognized that such vaccines would be valuable tools in venereal disease control, especially since few infectious diseases have been brought under effective control without suitable vaccines.

Comment

The Commission takes note of the encouraging reports of the artificial induction of immunity against syphilis in experimentally inoculated rabbits. These investigations provide a base for augmented studies of immunization with nonpathogenc treponemes, attenuated virulent treponemes, and treponemal antigen fractions. Although the rabbit results are not directly translatable to the human situation, they provide renewed incentive for the pursuit of a human vaccine. With respect to gonorrhea, the Commission is greatly encouraged by the recent development of a polysaccharide vaccine for meningococcal meningitis. It is well established that the meningococcus and the gonococcus are quite closely related mirobiologially and immunologically, and it is felt reasonable that some kind of vaccine could be produced against the gonococcus as well. The Commission believes that the spectrum of immunochemical techniques applied to the meningococcus and other bacteria should be applied on a broad front to the gonococcus.

2(b). That appropriate studies in humans be carried out according to established guidelines for assuring the rights and safety of the participants.

Comment

Realizing fully the many administrative and ethical questions involved with experiments involving human volunteers, the Commission nevertheless feels that certain aspects of venereal disease infectivity, pathogenesis, and prevention can be answered only by studies in human volunteers since no satisfactory animal models are available.

2(c). That renewed and intensive studies be undertaken to achieve the *in vitro* cultivation of *T. pallidum*, since this accomplishment is a vital necessity for the refinement of serologic tests for syphilis, vaccine development, and expansion of knowledge about the pathogenesis of syphilis.

Comment

Because the *T. pallidum* cannot at present be grown in cell culture or in artificial media, the organisms must be laboriously extracted from the tissues of living animals; only relatively small quantities of treponemes are available in this way, and the resultant suspensions of organisms are invariably contaminated by tissue components from the donor animal. Such contaminated suspensions of *T. pallidum* are not suitable in volume or purity for the immunochemical studies necessary to refine serologic tests, develop vaccines, and isolate antigens needed to study syphilis pathogenesis. Although many unrewarding attempts have been made during past decades to grow pathogenic treponemes in cell culture or tissue culture, the Commission feels that newer advances in these subjects should now be vigorously applied to *T. pallidum*, especially since other heretofore recalcitrant bacteria have recently been successfully cultivated by using innovative growth systems.

2(d). That research be continued and extended on the physiology, cell structure, antigenic composition, and genetics of *T. pallidum* and *N. gonorrhoeae*.

Comment

Development of better casefinding, therapeutic, and prophylactic techniques for syphilis and gonorrhea has been delayed in part because of fundamental gaps in knowledge about certain aspects of the causative agents. For example, knowledge of cell physiology is necessary to develop better local and systemic therapeutic and prophylactic agents; knowledge of the cell structure and antigenic composition is needed to produce and refine serologic tests and vaccines; and knowledge about the genetics of the organisms can help circumvent the emergence of antibiotic resistance.

3. That safe and effective topical or systemic prophylaxis for venereal disease be sought.

Comment

The possibility of chemical, mechanical, or antibiotic prophylaxis of venereal disease has received little attention in recent decades. Yet earlier experiences indicate that, properly used, chemical and mechanical prophylaxis do decrease venereal disease. The Commission endorses present research aimed at defining the effectiveness of locally applied contraceptive preparations such as foams, creams and jellies, and mechanical devices such as the condom. The Commission also urges that further research be undertaken to develop improved topical or systemic prophylaxis agents which will be readily acceptable to prospective users. Presently available antimicrobial agents have not been adequately evaluated for effectiveness for venereal disease prophylaxis; therefore, the Commission believes that it may still be possible to develop a formulation suitable for this purpose, and it urges that relevant studies be carried on.

4. That investigations be undertaken on the effect of newer contraceptive measures, such as birth control pills and intrauterine devices, on the susceptibility of individuals to infection with venereal disease.

Comment

It is unquestionable that newer contraceptive measures, such as birth control pills and mechanical devices, have an effect upon the physiological and biochemical environments in the cervix and vagina. The influence of such altered environments upon the infectivity and survival of venereal disease microorganisms needs to be studied.

5. That a continuing search be made for new efficacious antibiotics, and that monitoring of clinical and *in vitro* effectiveness of existing ones be continued.

Comment

Fortunately, for syphilis therapy, the *T. pallidum* organism has not yet shown an increased resistance to penicillin, and this drug continues to be the treatment of choice. This situation should continue to be monitored. On the other hand, the gonococcus has shown a steady increase of relative resistance to penicillin and alternate antibiotics, and investigators, including those in the pharmaceutical industry, must continue to seek new effective antibiotics. It is also necessary that the pace of emerging resistance be monitored so that revised therapy recommendations can be issued as needed.

6. That studies be undertaken to determine the effectiveness of current treatment of syphilis and gonorrhea, particularly of late latent and tertiary syphilis.

Comment

Although the treatment of primary and secondary syphilis appears to be reasonably well defined, it has been many years since the treatment for late latent and tertiary syphillis has been appraised. During that time, new penicillin preparations have come on the market, and the fact that many people cannot receive penicillin because of allergies has been revealed. No comprehensive studies of the newer penicillins and antibiotics other than penicillin have been undertaken in patients with late latent syphilis, tertiary syphilis, or syphilis during pregnancy. Such patients are relatively scarce, especially individuals who are allergic to penicillin, but the Commission feels that such treatment data must be accumulated insofar as practical. These data will be particularly important in light of the recent reports of spiral organisms, resembling *T. pallidum*, in the cerebrospinal fluid and aqueous humor of patients who have received adequate penicillin therapy for latent or late syphillis. A cooperative clinical group composed of outstanding venereal disease clinics should be organized to perform the necessary clinical and laboratory research. Also to hasten progress and increase the probability of obtaining reliable data and the proper interpretation of results, such a group should be utilized for other research projects; *i.e.*, determine the effectiveness and feasibility of chemical prophylaxis; provide dependable alternate antibiotic schedules for pregnancy; and document the incidence of complications in gonorrhea.

7(a). That detailed studies of the microbiology and immunology of uncomplicated gonorrhea, complications of gonorrhea, and on the pathogenesis of gonococcal infection be intensified.

Comment

Although gonorrhea has been a public health problem for a long time, the Commission is distressed to find that very little is known about the fundamental microbiology and immunology of the typical disease and its complications. Definition of the systemic and local antibody and cellular responses to gonococcal infection are vital to the development of improved serologic screening tests and vaccines. Knowledge of the microbial and immunologic parameters of gonococcal complications, and of the pathogenesis of these, will undoubtedly provide better diagnostic methods for identifying the complications and may provide means for forestalling their appearance.

7(b). That studies be pursued for the development of simple and practical laboratory animal models for gonorrhea.

Comment

Researchers studying gonorrhea have been greatly handicapped by the lack of animal models for this disease. Such animal models would be extremely helpful in the development of serologic tests, the study of pathogenesis of the disease and its complications, and in developing prophylactic techniques. A recent encouraging breakthrough is the establishment of model infections in male and female chimpanzees. These valuable studies should be pursued. Also, there still remains urgent need for the development of a less expensive and more practical model in more conventional laboratory animals. The Commission feels that innovative studies should be undertaken to develop such models, including the use of germfree and immunologically suppressed animals.

8. That investigations designed to improve diagnostic methods, including both immunological procedures and culture be more vigorously prosecuted.

Comment

The Commission recognizes that existing serologic tests for syphilis are quite useful but do have certain inadequacies which are costly in terms of resources. For example, the routine screening test picks up many false-positive reactions which must be resolved by the performance of a more expensive and cumbersome confirmatory test. Also, because present screening and confirmatory tests cannot differentiate between active infection and previously treated infection, many manhours are spent tracking down adequately treated cases. Present syphilis tests are also relatively insensitive to incubating disease, and some physicians require a positive test before they will treat a syphilis contact. A sensitive test for incubating syphilis would enable infected patients to be found before they develop the external lesions which can spread the disease to others. With respect to gonorrhea, present culture procedures seem adequate, but refinements should be made in terms of simplicity and speed. Because at present there is available no satisfactory serologic screening test for gonorrhea, maximal effort should be expended to develop and refine practical and inexpensive tests for this purpose. More than 38 million blood specimens for syphilis are tested annually, and a serologic test for gonorrhea could be applied to these with no further expenditure of effort in specimens collection.

9. That research into the effectiveness of current programs be undertaken.

Comment

Each element of the current control program should be evaluated and the demonstration and evaluation of new or modified techniques of casefinding be encouraged.

Until such time as new knowledge is developed which will make possible the development of immunity to the venereal diseases in the human host or the alteration of human behavior so that exposure to infection does not take place, the control of venereal disease will continue to rest largely on an attack on the causative agent through early casefinding and treatment. Our present approach is through the reporting of cases, the interviewing of cases for contacts, contact tracing, a variety of mass screening techniques and treatment of cases and, in some circumstances, suspected cases or exposed individuals. Techniques which are successful against syphilis may not be successful against gonorrhea; approaches which are effective in one socioeconomic setting are not necessarily effective in another; what works in a public clinic setting may prove to be inappropriate in a private physician's office. There is difference of opinion among experts about the effectiveness of virtually all of the elements of the control program. However, all of the elements are rational and have in some circumstances demonstrated their usefulness. It would seem prudent to investigate each of these elements to determine under what conditions they are effective or, possibly, deleterious, and then apply them as appropriate. It is certainly unwise to make drastic programmatic changes until specific activities are demonstrated with evidence to be ineffective or harmful or until a superior substitute has been developed.

10. That a group of investigators with expertise in sexually transmitted diseases other than syphillis and gonorrhea be developed and an appropriate unit with responsibilities for these diseases be established at the Center for Disease Control.

Comment

Although syphilis and gonorrhea are deserving of high priority because of their serious health consequences and the sheer magnitude of their incidence, the Commission recommends that other important venereal disease problems not be overlooked. Deserving of particular mention are: non-gonococcal urethritis, genital herpes, lymphogranuloma venereum, granuloma inguinale, and chancroid. The Commission is distressed to find that, for most of these diseases, there is not a single laboratory expert active in the United States today. For the remainder, only one or two individuals are active. Although a large national competency is not needed, the Commission feels that the country is precariously understaffed with regard to these conditions, and a modest augmentation of research workers and resources is indicated.

11(a). That the Federal Government increase its support for the study of human behavior and its relationship to the venereal diseases.

Comment

Although behavioral research on the venereal diseases is desperately needed, there seems to be no clear cut responsibility for encouraging funding of extramural research on this subject. After review of the various possibilities, the Commission feels that the National Institute of Mental Health, through its active interest in behaviorial science and its many contacts in universities throughout the country should, in close collaboration with other federal agencies, encourage and fund research on the behavioral aspects of venereal disease.

11(b). That studies be undertaken to design realistic educational programs to influence behavioral patterns amongst populations particularly susceptible to venereal disease and to determine the impact of educational efforts on the incidence to venereal disease.

Comment

The venereal disease problem is not confined to a single group in American society. Among the higher educational and economic segments of the population, venereal disease is increasing. If realistic educational programs are to be designed to influence behavioral patterns among susceptibles, it is essential to assess the present levels of venereal disease knowledge. Moreover, the use of educational programs will have wider appeal when it can be conclusively demonstrated that such programs have a measurable influence on the incidence of venereal disease.

11(c). That studies be initiated to discover factors which would motivate people to employ venereal disease prophylaxis, independent of their motivation to use contraceptives.

Comment

Contraceptive measures such as condoms and vaginal foams and jellies have an incidental "fallout" influence against venereal disease. However, the new and widely used contraceptive pills and intrauterine devices have little or no venereal disease prophylactic potential. Users of such measures will, therefore, require some additional motivation, beyond contraception, which would impel them to use venereal disease prophylactic measures as such measures are, or become, available.

11(d). That studies be undertaken to determine to what extent present methods of venereal disease case reporting and contact tracing may deter patients from seeking treatment, discourage physicians from cooperating, and affect the efficacy of veneral disease control programs.

Comment

Although case reporting and contact tracing procedures have been integral parts of venereal disease control programs for many years, few data are available to indicate whether certain elements of apparently valuable programs have, in fact, a negative aspect. Present methods may deter patients from seeking treatment and discourage physicians from cooperating. It is recommended that studies of these questions be undertaken to determine whether present case reporting and contact tracing procedures should be substantially modified.

12. That an advisory council on venereal disease with appropriate governmental and nongovernmental membership be established to make recommendations to the Assistant Secretary for Health and Scientific Affairs of the Department of Health, Education, and Welfare for the implementation of the research and control programs designed to reduce the incidence of the venereal diseases.

Comment

With the anticipated increase of resources for venereal disease control and research, it is desirable that a Department of Health, Education, and Welfare advisory council on venereal disease be established to assess national priorities on a continuing basis, make recommendations for necessary action, advise on the division of available funds and on the need for changes in the level of funding and promote coordination and liaison between relevant governmental groups and between these and nongovernmental groups.

C. PROFESSIONAL AND NONPROFESSIONAL EDUCATION

The National Commission on Venereal Disease recommends:

1(a). That the dean, faculty, and committees on curriculum of medical schools be made aware of the importance of including a minimal number of hours in venereology as part of a core curriculum, and that a faculty member

who has a primary interest in venereology be identified to coordinate the teaching efforts of the several clinical departments and the Department of preventive Medicine to assure that undergraduates will be introduced to an optimal amount of venereology. It is further recommended that such a faculty position be supported in part or totally by a federal grant of $20,000–$30,000 per year. Furthermore, the Commission recommends that the Center for Disease Control, Department of Health, Education, and Welfare, urge public health agencies to provide clinical materials to teaching hospitals for instruction in the genitoinfectious diseases.

Comment

It is generally accepted that basic knowledge is acquired best in the early years of professional education. The biologic characteristics, diagnosis and management of the genitoinfectious diseases and related human behavior, should be a portion of basic teaching in undergraduate education. The Commission makes this recommendation for undergraduate education in recognition of the widespread ignorance of practitioners in the diagnosis and treatment of the venereal diseases.

The many elective courses designed for the fourth year students permit only a limited variety of clinical experiences. Several hours on venereology in the final clinical year should serve as an introduction to the natural history and course of the genitoinfectious diseases. In addition, an hour or so on the epidemiology of these diseases should be taught in the Department of Preventive Medicine. The fourth year student, depending upon his choice of electives, might possibly see isolated manifestations, as for example, epididymitis or tubo-ovarian abscess of gonorrhea, aortitis or retinopathy of syphilis, or rectal stricture of lymphopathia, which he would then be capable of relating to the biologic spectrum of disease.

It was concluded that the recommendation of selecting an interested faculty member would be most likely to attain the immediate objectives in undergraduate medical education.

Because most patients with venereal disease go to private practitioners, too few such patients are seen in the teaching hospitals. Instruction must be in a teaching environment, and not by a visiting instructor who is "underfoot" in a busy public clinic. Only rarely has the harried, and often itinerant, doctor in the public venereal disease clinic, employed to give treatment, the attributes of an acceptable instructor. This recommendation recognizes the responsibility of the Department of Health, Education, and Welfare to cooperate with teaching hospitals in supplying, with financial support, clinical materials if needed for undergraduate (and graduate) teaching, either by establishing a clinic in the teaching hospital or by some other means.

The Commission deems it imperative that steps be taken to encourage the participation of university hospitals in the care of patients with venereal disease as an essential base for the instruction of medical students and graduate physicians, and for clinical investigation of these diseases.

The rapidly declining number of general physicians and specialists with adequate training in the venereal diseases, and the scarcity of competent investigators in this field is noted elsewhere in this report. This situation is believed to be due in part to the accelerating flow of patients from university hospitals to clinics which are not integral parts of those teaching centers. Medical education is based uniquely and essentially on the management of patients presenting various types of problems. Instruction which does not have this clinical base is usually poorly done. The prevention and treatment of the venereal diseases must again become one of the responsibilities of teaching centers if the continued deterioration of the quality of these services throughout the country is to be reversed. The problem involves economic as well as educational considerations to which serious attention should be given.

1(b). That the medical organizations oriented to family practice, emergency room practice, preventive medicine, as well as certain associations of specialists, and their Boards of Certification, emphasize the need for education in venereology at the level of graduate training in both university and community hospitals.

Comment

Although the Essentials for Internships and Residencies list the desirability of many interdisciplinary teaching exercises, venereology is not mentioned in any of them. Improvement in undergraduate instruction alone would raise the level of knowledge among the resident staff of university hospitals. However, teach-

ing at the graduate level is important, particularly in community hospitals, where a high proportion of house staff are graduates of foreign medical schools of whom many will remain to practice in this country. A means of providing such instruction may be by the proper education and orientation of the rapidly growing specialty of emergency room medicine. Directors of medical education in community hospitals should also be made aware of their responsibilities to provide experience in venereology, possibly with the cooperation of public health clinics.

The examinations of specialty boards for certification should include questions about genitoinfectious diseases appropriate to that specialty. Since much of the management of venereal disease is in the hands of the family physician, Boards of Certification for primary physicians bear a large responsibility in this regard.

1(c). That the several medical and health associations represented on this Commission be urged to promote appropriate presentations and discussions about the genitoinfectious diseases on the programs of their national meetings, and on the programs of their component societies or regional meetings, and to use their journals and other publications for the continuing education of their members. Furthermore, that they provide the leadership to include in the staff meetings of community hospitals, presentations illustrating the clinical aspects of the genitoinfectious diseases.

Comment

The American Medical Association has taken such steps not only in its own activities, but has urged that its component associations or societies involve themselves in attacking the problems of venereal disease. It has requested editors of journals of State associations to give attention to these matters. Both national and regional meetings of specialty organizations should use television programs, panels, symposia and other methods of instruction in continuing education. Review tapes should be available for the doctors' lounge in community hospitals. Since the members of such organizations may have rather specialized interests, the Center for Disease Control should support experts and make them available to speak on the programs of these societies. They should be available to speak at staff meetings in hospitals accredited for residencies and especially those which may have many residents of foreign education.

An ongoing program of continuing education in the genitoinfectious diseases would be assured by establishing committees for this purpose in the several associations.

2. That Schools of Public Health be urged to include, as part of their basic curriculum, subject matter about the venereal diseases and their control. It is further recommended that a faculty position be supported in whole or in part by a Federal grant of $20,000–$30,000 per year to those Schools of Public Health which institute venereal disease control training programs providing elective opportunities in addition to the inclusion of basic material about the venereal disease in courses required of public health students.

Comment

For many years the schools of public health provided information about the venereal diseases and their control in courses required of all public health students. Some of these institutions developed extensive elective programs for those individuals who wished to prepare themselves as specialists in venereal disease control. From these schools emerged not only a large group of health workers with a basic understanding of these diseases and control programs but a significant cadre of experts who provided leadership to venereal disease programs in the United States and in countries throughout the world. With the relative decline of the venereal diseases as a public health problem during the fifties, the decline of financial support for venereal disease programs, and the emergence of other fields which captured the concern of the public and health workers, the specialized programs disappeared. In addition, even basic, introductory information about these diseases tended to disappear from the curricula of the schools. These events coupled with similar changes taking place in medical schools and other schools of the health professions have led to a situation where graduates of these schools are largely uninformed. It is essential, in view of the increasing seriousness of the venereal diseases as a public health problem, that the schools of public health reinstitute programs in this field in order that an informed group of health professionals be made available to work in control programs and to serve as teachers and investigators.

3. That education concerning the venereal diseases be introduced into the curriculum of public, parochial and private schools no later than the seventh grade as part of a basic course in health sciences, and that such courses be taught by teachers or school health nurses who have had special training in the teaching of health sciences, including venereal disease. State departments of education and of health should collaborate in these efforts.

Comment

There is a deplorable inadequacy of both the teaching and the programs for instruction in health sciences in the school systems of a large part of the country. Courses in health sciences should include not only references to human anatomy and physiology, but also lay the groundwork for an understanding of the many facets of personal and community health. Among these, the infectious diseases are very important and specific attention should be given to the venereal diseases. It is essential that these courses be offered to all students and in mixed or coeducational classes. Since the attitudes of many teachers preclude an unemotional approach to the teaching of health sciences, and particularly about venereal disease, special training should be provided for selected teachers. Teachers' colleges should specifically prepare teachers for this assignment. School health nurses would seem especially fitted to teach the health sciences.

Collaboration of State departments of education and of public health might result in the production of effective educational tapes, programs for closed circuit television and assignments by personnel from health departments for class work.

The President's Committee on Health Education should be made aware of the urgent need for education about the venereal diseases and this Commission should offer itself as a source of information in this area.

4. That the Federal Government initiate and support a program of public education and information similar to that carried on by the National Clearinghouse on Smoking and Health. It should include information concerning signs and symptoms, prophylaxis, prevention, and facilities for treatment and should be geared to the various consumer groups concerned.

Comment

The Commission recognizes the impact which the printed world in newspapers and magazines, and the spoken word on radio and television, has upon the public. The effects are immeasurable and probably have a role in all of the recommendations for action described above. Such programs may (1) point up the importance of a course in health sciences for the public schools; (2) influence parents to initiate support for school boards and teacher groups active in innovative moves toward health education and education in the venereal diseases; (3) give active support to appropriate images of youth working for better health among their peers; (4) be a potent factor in supporting and amplifying activities of civic groups in venereal disease education; (5) strengthen venereal disease information as offered by those involved in medical and health care services; and (6) support similar programs of education in medical departments of industry or business.

It is recognized that the communications industry often with the support of private groups, either in industry or from nonprofit health organizations, has given considerable attention to public education in health and more recently in venereal diseases. However, for an ongoing and augmented program, it is essention that federal funds be directed toward this endeavor. The successful experience with the program in health education of the National Clearinghouse on Smoking and Health indicates that a similar approach in venereal disease would achieve equal success.

In this program the government should enlist the continued support of the mass media and other interested private groups to assure an adequate and continuing effort.

The media should be encouraged to accept advertising in newspapers and magazines, emphasizing prophylaxis.

5. That Schools of Nursing, of Dentistry, and of Pharmacy, and newly developing schools for the training of Allied Health Professionals, as well as institutions or agencies training nonprofessional workers be urged to include in their curricula adequate instruction about the venereal diseases.

Comment

This recommendation recognizes the large role that Physicians' Assistants may have in history taking, physical examination, special examinations such as bac-

terial cultures and Pap smears, and treatment as delegated by the employing physicians. More and more, graduate nurses will play major roles in industrial medicine, public health nursing, in clinics, neighborhood health centers etc. with attendant implications in venereal disease control. Increasingly, nonprofessional training is being given to indigenous, peer, family, and other community workers in matters of health and hygiene. They should have a firm grounding in the venereal diseases.

6. That private civil organizations be urged to mobilize local resources in undertaking programs in venereal disease education.

Comment

The contributions which nonprofessional segments of the population can make toward the health of a community are well known, not only in raising money, but in initiating and continuing programs of education in health and the prevention of disease. Several service organizations have, on a national scale, shown interest in the problem of veneral disease and have promoted programs of public education. The sponsorship by responsible organizations in a community has an immeasurable effect upon attitudes and acceptance of innovative action within the community. Such organizations have political influence upon local government and school boards.

7. That everyone providing services in medical and health care offer education or information on venereal diseases to their patients and to others for whom they have a responsibility. The Commission also recommends that those engaged in industrial and occupational medicine in the medical branches of the Armed Forces who have a responsibility for large populations at risk to provide information about the venereal diseases with particular emphasis on prophylaxis.

Comment

Persons involved in providing medical and health services have an excellent opportunity to inform those seeking medical advice by offering printed matter concerning the venereal diseases and their prophylaxis if appropriate. Health departments in industry commonly manned by nurses can provide much information, both verbal and by leaflets or booklets, to the employees at the time of employment and periodic examinations.

Large segments of the population who visit public health clinics, community health centers, and health maintenance organizations for medical or preventive care can be reached in a similar manner. Physicians, Physicians' Assistants, and other personnel in offices and hospitals have the opportunity of providing advice about the venereal diseases and their prophylaxis, whether by word of mouth or by the printed word. Pharmacies with proper displays can reach many in the public. Voluntary groups providing health education and/or treatment to "street people" have the opportunity to offer information to many young people at risk.

The Commission recognizes the worth of education in the Armed Forces concerning venereal disease, control and prophylaxis, as was carried out in World War II. The Armed Forces, therefore, can contribute to the education of a large segment, especially of the male population.

8. That the Venereal Disease Branch of the Center for Disease Control establish a section for professional and public education with a full-time director to produce educational materials and to assist professional organizations develop educational programs.

Comment

Such director should have a senior rating with an attendant salary and a budget to develop film strips, motion picture films, and written materials for education of the profession and of the public. His budget should permit the support of short courses in continuing education in the venereal diseases for interested professionals. He might provide the "clearinghouse" for a panel of speakers to be available for meetings of professional societies.

D. LAWS AND REGULATIONS AT FEDERAL AND STATE LEVELS

The National Commission on Venereal Disease recommends:

1. That the Federal Government make changes in existing laws and regulations which (a) would authorize, as under Public Law 91–623, the Department of Health, Education, and Welfare to assign commissioned officers to State and local areas for venereal disease control activities; (b) require that all health care facilities, which provide general medical services or more

limited health care services make available diagnostic testing for the venereal diseases and treatment for these diseases to those patients found to be infected if the programs are to be considered eligible for federal sponsorship; and (c) require that in order to be eligible for federal support, facilities or programs which provide treatment for venereal disease patients use adequate treatment schedules which have been demonstrated to be economical, safe and effective.

Comment

(a) There is currently a dearth of physicians working in the veneral disease control programs. Many of those now performing clinical control activities are ill-prepared for work in these areas, and practically none are directing their energy and talent to these programs on a full-time basis. It would be possible through the institution of short-term training programs to make available a trained, qualified cadre of young physicians for work in the veneral disease field. Assuming that even relatively small numbers of such officers could be assigned to State and local areas, the most serious deficits in our existing programs could be vastly ameliorated. Furthermore, such activities could aid materially in meeting the same goal as that of Public Law 91–623 which is ultimately to improve the health care services in areas of the nation which now suffer from a shortage of physicians. Physicians trained to work in veneral disease and assigned appropriately would not only raise the level of care available to venereal disease patients but, through their activities in the prevention of venereal disease, have an even greater effect on the health of the population in these areas.

(b) The Federal Government, through many programs, is currently subsidizing and sponsoring groups providing health care services to local populations. For example, the various Office of Economic Opportunity medical programs and the new family planning clinics provide local services and are funded in whole or in part from federal sources. In most of these programs, venereal disease diagnostic services are provided, often on a regular routine basis for all admissions. It should be required of such clinics and programs that such services be provided if federal funds are to be made available. Unfortunately, there is no provision for the treatment of patients found to have venereal disease in many of these facilities. Furthermore, many individuals identified as being infected with a venereal disease do not get to other sources of care which do provide veneral disease therapy. It is extremely important that this sizable reservoir of infection be rendered noninfectious through treatment and that followup services and appropriate therapy be made available through those facilities which identify them. Otherwise, a golden opportunity for positive control action is largely lost.

(c) From time to time and for a variety of reasons, certain programs or clinics are persuaded to use drugs, routes of administration or schedules of treatment which have not been subjected to rigorous clinical assessment. Occasionally, such procedures are subsequently determined to be ineffective in the treatment of the disease for which they are used. Less frequently it may be found that they expose the patient to unnecessary risk of side effects. In considering the introduction of new drugs into routines of venereal disease therapy, there are two additional factors which must be weighed. First, drugs should not be used which are comparatively expensive but possess no compensatory advantage in terms of safety or efficacy. Second, one of the reasons that penicillin is considered the drug of choice in the treatment of gonorrhea is its effectiveness in the treatment of syphilis (for which it is also the drug of choice) and its capacity for aborting unsuspected or undiagnosed, incubating syphilis. It seems only reasonable that federal funds not be used to support programs using treatment schedules which have not been demonstrated to measure up on all of these scales. Obviously, this recommendation is not intended to preclude properly planned and conducted clinical trials or deviation from routines in the management of an individual for medical indications such as penicillin sensitivity.

2. That every effort be made to secure legislation in all States which will (a) permit physicians to treat minors for venereal disease without parental consent and, if a specific age restriction be included in such legislation, the minimum age at which such action may be taken be set at no more than 13 years of age; (b) encourage all laboratories performing serologic tests for syphilis or cultures for the gonococcus to report positive tests to the State health authorities; (c) require prophylactic treatment of infants at birth for the prevention of ophthalmia neonatorum; and (d) permit the free sale of venereal disease prophylactics, particularly condoms, to individuals regardless of age or marital status.

Comment

(a) One of the major problems in the control of venereal disease has always been the individual who hides his disease and refuses to seek treatment. The usual reason is fear that as a result of such disclosure some penalty will result. The most common problem of this sort at present is encountered in teenagers who fear parental displeasure or social ostracism more than they fear the disease. This results in unnecessary spreading of the disease. Where physicians are allowed to treat these young people without notification of the parents, early case finding and treatment can be much more adequately carried out. Four States do not now have laws allowing the treatment of minors without parental consent. Unfortunately, even where such laws exist, there is a great lack of uniformity, and many States have set unrealistically high ages below which treatment may not be given without parental consent. In the carrying out of this recommendation, it would be hoped that a model law might drafted under the auspices of the Center for Disease Control, and efforts made to introduce such laws where they do not exist or to modify appropriately the present inadequate laws.

(b) Over the years, one of the most effective adjuncts to syphilis casefinding programs has been the intelligent followup of psoitive serologic tests. It is estimated that there are approximately 38 million such tests performed annually in the United States and that, of these, roughly 1.1 million are positive. While the majority of the reactors are already known to have had adequate treatment or, for other reasons, to be noninfectious, many are individuals who require treatment for their own safety as well as that if the general public. A significant number of these would be lost to treatment if followup were not instituted by appropriate health authorities. It seems unfortunate that this opportuniy is not seized by those 11 States not having such legislation. While there has been limited experience with legislative or regulatory requirements of this type in the control of gonorrhea, it would appear to be an unfortunate omission from our control armamentarium. Such requirements would provide a valuable epidemiologic entree into the control of gonorrhea and additional information regarding the incidence and distribution of the disease as are currently available in syphilis control.

(c) In 1911, North Dakota passed the first State law requiring that, at the time of birth, the attendant instill "some germicide of proved efficacy" into the eyes of the newborn child in order to prevent the occurrence of ophthalmia neonatorum. By 1949, every State except New Jersey had such a law or health department regulation in force. Many laws specified that the drug used must be a 1 percent solution of silver nitrate. With the advent of penicillin and other antibiotics, there was a movement to allow the use of such agents and other silver preparations, and many laws and regulations were changed to permit this. Now, primarily because of the dangers of sensitization, such authoritative groups as the Food and Drug Administration and the American Academy of Pediatrics have issued strong statements to the effect that the so-called Crede method is the only acceptable procedure. It is strongly recommended (i) that those three States not now having such laws or regulations on the books pass or reinstitute them; (ii) that all States modify laws or regulations to require the use of 1 percent solution of silver nitrate or an equally effective and safe prophylactic agent approved by the State health authority and (iii) that all State health authorities require, at the present time, the use of 1 percent silver nitrate and make this freely available in fresh solution to all individuals and institutions providing obstetrical and newborn care until such time as improved or equally safe and effective agents are available. Provision should always be made in laws and regulations to allow properly planned and executed clinical trials of promising new agents.

(d) Many States have statutes which regulate the sale of prophylactics, particularly condoms. Most of these laws were primarily aimed at the prevention of the sale of contraceptive devices. These laws may restrict their sale except to married individuals regardless of age or prevent the sale to minors. Such restrictive laws interfere with the distribution of preventive devices to individuals seriously in need of any protection which can be made available. Since other preferred methods of contraception are readily available, it would seem that such laws are not only anachronistic but an actual deterrent to venereal disease control efforts.

E. CLINICAL FACILITIES AND OPERATION AND CLINICAL MANAGEMENT

The National Commission on Venereal Disease recommends:

1. That federal, State and local governments make a strenuous, concerted effort to improve the organization and management of venereal disease clinics, to upgrade the quality of care rendered in these clinics and to provide facilities which allow the maintenance of reasonable standards of privacy and dignity for patients.

Comment

While there are gratifying exceptions to the following generalizations, it is believed that these comments reflect fairly a major problem in the implementation of an effective control program. It should be obvious that most persons with an illness or suspected medical problem will tend to shun sources of care which are inconveniently located or operated at inconvenient hours; where the staff are impersonal, inconsiderate or even debasing in their actions or attitudes towards patients; where medical management of individuals is known or considered to be inept; and where the physical setting is dirty, cold or unattractive and of such an arrangement that physical examinations cannot be conducted in private, interviews of a very personal nature must be carried out within earshot of others or treatments administered simultaneously to groups rather than on an individual basis. Nonetheless, the bulk of our venereal disease clinics operate under several of the defects listed. It is evident that good clinics and other treatment sources are the keystones of any control program dependent upon early diagnosis and treatment for its success. In fact, it has been demonstrated that the best single measure of a venereal disease control or clinic program is the proportion of its clientele which presents itself voluntarily for treatment or diagnosis. In view of this it seems incredible that our clinics have been allowed to reach such poor standards.

Each clinic should have a physician present at all times during its operation and in charge of all aspects of its activities. The physician must be knowledgeable concerning the diagnosis and treatment of the venereal diseases; have a grasp of the fundamentals of venereal disease control and the appropriate roles and responsibilities of other members of the clinic staff; be sensitive to the human needs of his patients and be professional in his demeanor. Increasingly the medical personnel working in our venereal disease clinics are inadequate on one or more of these counts and frequently are not in charge of the clinics. Terms of employment should be improved sufficiently to attract physicians of high caliber to these positions and training programs arranged by federal, State and local agencies, alone or in conjunction with teaching institutions to provide the physicians with the necessary background. Appropriate training programs should be established for other venereal disease clinic personnel, both professional and nonprofessional.

Clinics should be situated so as to be conveniently reached by the majority of patients in the area which it serves and open during hours when they can attend without loss of time from work.

While the facilities do not need to be palatial or plush, they can be made neat, clean and attractive and located in desirable settings. Most important of all, and hence reemphasized, is the need for an atmosphere which leads the patient to feel that he is receiving first rate care in a dignified manner from clinic personnel who are concerned about him and his problem.

Finally, the effectiveness of these facilities can be considerably improved if their services are broadened to include the management of such commonly related conditions as venereal warts, pediculosis, trichomoniasis and scabies. It is difficult for patients (and the Commission) to understand why a patient with gonorrhea cannot be treated concurrently for scabies in the same clinic.

2. That all diagnostic and treatment facilities, whatever their nature or setting, be encouraged to avail themselves of every reasonable opportunity to perform routine diagnostic tests for the venereal diseases.

Comment

Over the years, routine diagnostic tests for syphilis have provided a major casefinding source. With the advent of increasingly efficient and practical culture

techniques and facilities for the identification of the gonococcus, a new diagnostic dragnet has become available. Because of the difficulty of diagnosing gonorrhea in the female by means other than cultures, the recognition that asymptomatic gonococcal infection of the male urethra is more common than previously supposed and the relative frequency of gonococcal proctitis in both males and females, it is important that gonococcus culture techniques be much more widely applied. The Commission does not believe that the routine testing for venereal disease of all patients seeking care at hospitals or clinics should be required for purposes of accreditation. However, it does strongly recommend that physicians and the medical institutions in which they serve be made fully aware of the frequency of venereal disease among patients coming for care and the practicality of instituting routine screening for these diseases in many if not all groups of patients seeking care.

F. PUBLIC HEALTH AND PRIVATE MEDICINE

The National Commission on Venereal Disease recommends:

1. That medical specialty groups establish standing committees on the venereal diseases with mechanisms for communication among and joint action by these committees.

Comment

The medical specialty groups are in a position to increase the awareness among their colleagues of the rising incidence of the veneral diseases in all segments of our society. They can also influence their members to inform themselves regarding new developments in the diagnosis and treatment of these diseases, and to cooperate fully with public health officials in efforts directed toward their control. By joint efforts, they can do much to inform the general public and the health professions as a whole regarding this group of diseases and elicit their support for venereal disease control activities. Also, the certifying boards can be encouraged to reflect an awareness of the importance of the veneral diseases in the practice of their specialty by the inclusion of appropriate material in their examinations.

2. That each State and, where appropriate, local government establish permanent commissions or similar advisory groups with representation from medical and other health professional groups, legislative bodies, and the general public to advise the cognizant public health officials on their venereal disease control programs. It further recommends that State and appropriate local medical societies establish standing committees with similar responsibilities, particularly where advisory groups are not established by government.

Comment

Groups such as these assure that continuing attention will be paid to the venereal disease problem and to the needs of the control programs. They also can view with new and broader perspectives and, probably, greater objectivity the content and progress of a control program that can those individuals involved with them on a daily basis. Finally, they can provide a broad base for backing such programs and enhance the likelihood of adequate support from the public and the executive and legislative branches of government.

Medical Society commissions or committees can serve the same purposes as those listed above. In addition, they can be very influential in encouraging the establishment of close, cooperative working relationships between private medicine and public health in all elements of the control effort.

3. That venereal disease control officers and other appropriate health department personnel make every effort to establish effective liaison with the so-called "free clinics" and similar institutions which are providing an increasing proportion of the medical care, particularly in urban areas.

Comment

The "free clinics" are growing in numbers and attract an ever larger clientele. A considerable proportion of the patient population consists of young people and particularly those who are averse to patronizing medical care sources identified as being part of the establishment. These groups are particularly liable to enjoy high venereal disease rates. Health authorities and responsible physicians working in these clinics should make every effort to see that these patients receive good diagnostic and treatment services, that they are informed regarding the potential seriousness of the diseases and how to protect themselves against infection, and

that they are aware of the benefits to themselves and their friends through cooperation in casefinding efforts. The venereal disease control officer can be helpful to these clinics by making available to the staff educational material for the physicians and patients, consultative and diagnostic laboratory services, drugs for the treatment of venereal disease, epidemiologic services and the like.

G. FUNDING OF VENEREAL DISEASE CONTROL

Discussion of Sources of Support of Venereal Disease Control Programs

The venereal diseases have always been a matter of concern to national governments but, until recent times, primarily in relation to their military forces and their merchant marine; these governments have also provided treatment to those groups considered to be wards of the State. The State and local governments have similarly provided treatment for the venereal diseases as for other conditions under programs of medical care for the indigent. Federal and State governments also concerned themselves with legislation against prostitution and the enforcement of such laws, in part at least, on the grounds that it contributed to the spread of disease.

National Venereal Disease Control Act—1938

It was not until the 1930's that the United States, under the leadership of Surgeon General Thomas Parran, mounted a substantial nationwide campaign for the control of venereal disease, and especially of syphilis. This was reflected in the passage of the National Venereal Disease Control Act in 1938. This Act made available funds for activity at the federal level consisting of the development of a large group of individuals with expertise in the venereal diseases and their control, public education programs, assistance to the States in promoting and developing venereal disease control programs through the provision of funds and assignment of personnel, the establishment of demonstration projects and the support of research, both within the Public Health Service and by outside groups. This federal involvement in a national venereal disease control program has continued to the present though with the passage of the Partnership for Health legislation in 1966, the federal mechanism for funding was fundamentally altered. Under the National Venereal Disease Control Act, all States either bolstered their existing programs or initiated such endeavors.

Present Total Venereal Disease Control Expenditures

At the present time, it is estimated that the total expenditures by all levels of government for venereal disease control activities is approximately $43 million, of which roughly 30 percent is provided by the Federal Government. The total annual costs due to venereal diseases in the United States are estimated to be $364 million if both direct and indirect costs are considered.

Discussion of Mechanisms of Federal Support of Venereal Disease Control

There are a variety of channels through which federal funds flow into the overall venereal disease control effort. Obviously, since the military and civilian venereal disease problems are to a large degree inseparable, the funds spent by the Department of Defense in its venereal disease control activities and its treatment program are substantial. Similarly, the Veterans Administration has a small portion of its funds spent in the treatment of such cases. Also, funds are directed to the diagnosis and treatment of venereal diseases through many channels, for example, the Office of Economic Opportunity medical programs and family planning programs. The most significant contribution is through the Department of Health, Education, and Welfare. In theory, at least, it is possible to secure funds for research through the National Institutes of Health research grant mechanism, but in actuality, there are no specific funds set aside for research in this area and only insignificant amounts have been awarded. The same can be said for research training grants from the same source and health manpower training grants through the Bureau of Health Manpower Education though in these instances the amounts spent are nonexistent or inadvertent. The main stream of support is administered through the Venereal Disease Branch of the Center for Disease Control. This Branch, in fiscal year 1971, had available to it $5,834,000 for its direct operations and $6,300,000 for grants in funds "set aside" for the purpose, there being no specifically designated funds appropriated for venereal disease control grants. During the current year an additional $16 million was appropriated which could be used in venereal disease work, intended primarily for gonorrhea control activities. Present mechanisms

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for funding have proved to result in inadequate and uncertain support for all aspects of our national effort.

Venereal Disease Project Grants Effective

It is clear that one of the effective elements of any federal venereal disease program is the availability of funds for grants to States. During the years when these grants were derived from specifically designated venereal disease appropriations, the ground rules for the award of project grants were clear. For many years, project grants were made to States for venereal disease control activities based on the size of the venereal disease problem, interest and willingness of the State to initiate a program, and financial resources of the individual State, assuming that a satisfactory venereal disease control plan and application for funds was submitted.

Partnership for Health Legislation

The field of health is no different from other areas of our national political scene. There are always proponents of greater decentralization of decision-making and of the pulling together of more and more small programs into a smaller number of larger programs in terms of legislation, appropriation and administration. Such moves also have their bitter opponents. The mid-sixties saw the first of these groups gain supremacy and the Partnership for Health legislation was passed. Among other purposes, the thrust of this legislation was to eliminate categorical health program appropriations for aid to States and transfer authority for the planning of health programs and utilization of federal grant funds for these activities to State and regional planning agencies. In theory, at least, this has many attractions. It relieves the federal executive branch from responsibility for certain detailed planning and initiatives. It should relieve the Congress to some extent of hearings on a large array of categorical programs. Conversely, more responsibilty is forced upon States and regions for the planning and implementation of its health programs and presumably they should be more aware of local needs and conditions. In theory, the States submit plans for these programs and the use of the federal funds, which are reviewed by the cognizant federal authorities for adequacy before the funds are released.

Unfortunately, it does make for great difficulty in maintaining a nationwide categorical program with minimal qualitative and quantitative standards. There is no assurance that federal funds in any quantity will be directed in a given State towards a specific program even one with a high national priority. It seems to be impossible to establish and enforce any sort of minimum standards for the various elements of a comprehensive health plan. It is generally conceded that total appropriations for health grants to States are less than the sum of a series of more categorical and understandable programs. From the standpoint of some federal legislators, it has the undesirable effect that the Federal Government loses much of its ability to exercise control over the expenditure of federally appropriated funds for which it is responsible to the taxpayer.

Earmarked Funds and Minimum Program Standards

It seems evident to the Commission that, if an organized national venereal disease control program is to be successfully carried out, some device either within or without the comprehensive health planning mechanism, must be invoked which results in all of the State and local governments having adequate venereal disease control programs meeting some minimum standards established by the Federal Government if federal funds are to be made available to the State and local governments. There should also be a requirement that federal funds be used to supplement and not to supplant State and local funds. This could be accomplished by a return to specific venereal disease control appropriations for grants-in-aid to States or by the earmarking of funds within the comprehensive health planning appropriations but in either event a federal review mechanism should be established and minimum program standards set.

Funding of Educational Programs and Research

The several recommendations regarding the control programs, including public education, research of both a basic and applied character and professional educa-

tion have underlined the multitude of fronts on which this particular war must be waged. The channels through which federal funds may flow in support of venereal disease control with the exception of State grants discussed in the preceding paragraphs are reasonably clear. Even in the case of research, research training and health manpower education grants, however, it seems clear that specifically earmarked funds will be required if capable individuals are to be attracted to the field in adequate numbers. The Commission does not believe that it should attempt to detail the exact manner in which funds should be allocated to the various administrative units of the Department of Health, Education, and Welfare, but does, in its various recommendations on appropriations, attempt to list the various elements of the total program and place a reasonable cost figure on each of these elements.

Recommendations for Funding

The Commission strongly recommends that appropriations and expenditures for the venereal disease control activities of the Department of Health, Education, and Welfare be substantially increased. While all elements of the program require augmented appropriations, it is recommended that significantly higher proportions be allocated to public and professional education and research than has previously been the case. In strengthening the operational control program, State and local governments should be persuaded to assume financial responsibility for an increasingly large proportion of the total effort.

1. The Commission recommends that federal funding for Venereal Disease Branch operations and for project grants to States in the amount of $35,450,000 be appropriated, allocated and obligated for fiscal year 1973, increasing to $43,300,000 in fiscal year 1977. [Table I presents an explanation of how these figures were derived.]

TABLE I.—RECOMMENDED DHEW FUNDING LEVELS—IMPLEMENTATION AND MANAGEMENT OF NATIONWIDE VENEREAL DISEASE CONTROL PROGRAM

[Excluding new research and professional education, tables II and III]

	Fiscal year (dollars in thousands)					
	1972	1973	1974	1975	1976	1977
Project grants to States for VD control	[1] $22,300	$25,000	$28,000	$30,000	$30,000	$30,000
VD branch operating funds:						
(a) Administration, technical assistance, ongoing research, etc	3,873	5,000	5,300	5,625	5,975	6,325
(b) Personnel assigned to States	1,657	2,500	2,650	2,800	3,000	3,250
(c) GC control pilot study contracts [2]	400	750	800	850	900	950
(d) New elements: Expanded educational activities including speakers bureau, national clearinghouse, and additional professional personnel		2,200	2,325	2,475	2,625	2,775
Total, operating funds [3]	5,930	10,450	11,075	11,750	12,500	13,300
Grand total	28,230	35,450	39,075	41,750	42,500	43,300

[1] Fiscal year 1972 appropriations under sec. 314(e) and 317 of PHS Act.
[2] VD control demonstration contracts.
[3] VD line item of communicable disease appropriation.

2. The Commission recommends that federal funds in the amount of $6,500,000 be appropriated, allocated and obligated for implementation of the venereal disease research program for fiscal year 1973, increasing to $19,500,000 in fiscal year 1976. Of these funds, two-thirds would be for extramural research. Table II presents a more detailed explanation of how these total figures were derived.

TABLE II.—RECOMMENDED DHEW FUNDING LEVELS—NEW VENERAL DISEASE RESEARCH

[In thousands of dollars]

	Fiscal year—				
	1973	1974	1975	1976	1977
Extramural research:					
(a) Basic:					
Treponemal infection	1,000	1,500	2,000	3,000	3,000
Gonococcal infection	1,000	1,500	2,000	3,000	3,000
Other, including herpes	200	500	1,000	1,000	2,000
(b) Prophylaxis	500	1,000	1,000	1,000	1,000
(c) Clinical	500	1,000	1,000	1,000	1,000
(d) Epidemiologic studies and evaluation of control methods	600	1,000	1,200	1,500	1,500
(e) Behavioral	500	1,000	1,200	1,500	1,500
Total, extramural research	4,300	7,500	9,400	13,000	13,000
Intramural research [1]	2,200	3,750	4,700	6,500	6,500
Grand total, research	6,500	11,250	14,100	19,500	19,500

[1] Allocated to categories in substantially the same proportions as shown for extramural research.

3. The Commission recommends that federal funds in the amount of $4,200,000 be appropriated, allocated and obligated for implementation of a venereal disease professional and nonprofessional educational program for fiscal year 1973, increasing to $5,235,000 in fiscal year 1977. [Table III presents a detailed explanation.]

TABLE III.—RECOMMENDED DHEW FUNDING LEVELS—VENEREAL DISEASE PROFESSIONAL EDUCATION

[In thousands of dollars]

	Fiscal year—				
	1973	1974	1975	1976	1977
Grants to schools of medicine and public health for faculty member	3,150	3,350	3,500	3,700	4,000
Projects grants for VD training programs in professional schools	875	950	1,000	1,000	1,000
Associated traineeships	125	130	140	150	160
Research traineeships	50	55	60	70	75
Research traineeships	50	55	60	70	75
Total, professional education	4,200	4,485	4,700	4,920	5,235

4. The Commission recommends that for all elements of the veneral disease control effort the Federal Government appropriate and expend through the Department of Health, Education, and Welfare in fiscal year 1973 a total of $40,150,000, these sums increasing to $68,035,000 in fiscal year 1977. No specific recommendations regarding specific legislative mechanisms are made, though it is clear that unless authorizations for continued appropriations under Section 317 of the Public Health Service Act are enacted, a change in the channeling of funds for grants to States will be needed. Also, no specific recommendations are made regarding the administrative unit or units of the Department of Health, Education, and Welfare which can most appropriately have responsibility for the various new elements of the program.

Table IV presents a more detailed explanation of the derivation of the figures recommended above.

TABLE IV.—RECOMMENDED DHEW FUNDING LEVELS—ALL VENEREAL DISEASE PROGRAM AREAS (SUMMARY)

[In thousands of dollars]

	Fiscal year—					
	1972	1973	1974	1975	1976	1977
Project grants to States	22,300	25,000	28,000	30,000	30,000	30,000
VD branch operating funds	5,930	10,450	11,075	11,750	12,500	13,300
Professional education		4,200	4,485	4,700	4,920	5,235
VD research (new)		6,500	11,250	14,100	19,500	19,500
Grand total	28,230	46,150	54,810	60,550	66,920	68,035

Appendix I.—Venereal Disease Control Activities in the United States Throughout the Years

The Venereal Disease Division was created within the Public Health Service in 1918 when studies showed that 5.6 percent of persons enlisting for military service in World War I had evidence of some type of venereal infection. The newly formed Division was funded with a one million dollar appropriation in each of the fiscal years 1919–20, and provided consultation, information and financial support for the establishment and operation of State venereal disease control programs. However, federal interest in venereal disease control soon waned and funds were cut so severely that the Division could not continue to coordinate and support a nationwide attack on the problem.

In 1939, Congress increased appropriations to $3,080,000, due largely to the efforts of Dr. Thomas Parran, then the Surgeon General and former Chief of the Venereal Disease Division, and a nationally coordinated program of casefinding and treatment was implemented throughout the nation.

A basic tenet of the 1939 control program was that there should be no economic barriers to diagnostic and treatment services for any person. The number of free clinics for diagnostic and treatment services were increased. Private and public physicians and institutions were encouraged to screen their patient population.

During the years 1939–47 the number of reported cases of syphills in all stages rose to a peak in 1943, and then began to decline. Primary and secondary syphilis peaked in 1947. During this period mortality due to syphilis declined rapidly.

The decline of syphilis mortality and insanity which has begun in 1939 declined at an accelerated pace with decreases from 1947 to 1957 of 59 percent in deaths and 79 percent in syphilitic psychotics admitted to hospitals. Reported cases of syphilis in all stages declined by 65 percent. Reported cases of primary and second syphilis declined by 94 percent.

To many observers it appeared as if the problem of venereal disease was soon to be a problem of the past and federal control appropriations were decreased from an all time high of $17,325,000 in 1948 to $3,000,000 in 1955. Factors other than declining incidence which influenced federal appropriations were competition from other federal programs for funding and a philosophy of relegating back to the States some of the governmental functions which had been taken on by the Federal Government.

A relatively small national increase in early syphilis cases was reported in 1958, but by 1960–61 cases were increasing at 50 percent per year. Similarly, gonorrhea also increased by a small margin in 1958 and continued to increase thereafter annually.

In 1961, the House Appropriations Committee requested a reassessment of the venereal disease control program. In response to this request, Surgeon General Terry, acting on the recommendations of the Public Health Service advisory

committee on the venereal disease control, appointed a Task Force headed by Dr. Leona Baumgartner, Health Commissioner of New York City, to review the syphilis problem and make recommendations for a course of action which would lead to the eradication of syphilis as a public health problem.

This Task Force recommended that an intensive effort be inaugurated to enlist the cooperation of the private physician in the control program, and that interview investigation services be intensified and extended to cover all infectious syphilis cases. They further recommended establishment of procedures to insure that all laboratories processing blood tests for syphilis cooperate in the control effort. The Task Force recommended that a comprehensive and dynamic education program be developed for professional workers as well as for the public. It urged that research in syphilis immunology, therapy and laboratory procedures be continued and greatly expanded. It stressed the importance of studies in behavioral sciences. The Report ended by urging that, as the reported infectious syphilis morbidity curve begins to drop, the Federal, State, and local governments continue unstinted support of the program. "Past experience with premature reduction in budgets have been followed by increases in cases and must be avoided."

Since 1962, organized medicine has officially endorsed the activities of the venereal disease control program and has encouraged their individual members to do likewise. However, the success of the program to secure better cooperation from individual practicing physicians appears to have been very limited, at least as measured by studies of case reporting practices. In 1968, the American Social Health Association in cooperation with the American Medical Association, the American Osteopathic Association, and the National Medical Association, conducted a nationwide survey of the reporting practices of private physicians. Although these physicians were treating approximately 80 percent of the cases, only 18.7 percent of primary and secondary syphilis cases were reported to the local health authorities.

When the Task Force Report was issued, 14 States had a law or regulation which required all laboratories to report positive serologic findings for syphilis to the health department. Today, 39 States plus the District of Columbia and Puerto Rico have a reactor notification law or regulation. As a result of this, reporting effectiveness, as far as serologic testing is concerned, has risen from about 34 percent in the first year of the Task Force implementation to about 73 percent in fiscal year 1970.

Prior to July 1, 1967, funds were granted by the Venereal Disease Branch to the States from federal funds appropriated specifically for veneral disease control. This categorical project grant system was eliminated beginning July 1, 1967, with the implementation of the Partnership for Health legislation. Under this new authority, veneral disease control needs had to compete with other health needs for funding from a generalized health project grant appropriation (Section 314(e) of the Public Health Service Act). Between 1968 and 1971, venereal disease control project grants were awarded from Section 314(e) at the same level as prior to 1968, but the purchasing power of these dollars has been substantially eroded through inflation. Some States lost all grant support, and case finding personnel dropped markedly throughout the country. The loss of categorical grants also weakened federal coordination in venereal disease control.

APPENDIX II.—MEMBERSHIP NATIONAL COMMISSION ON VENEREAL DISEASE

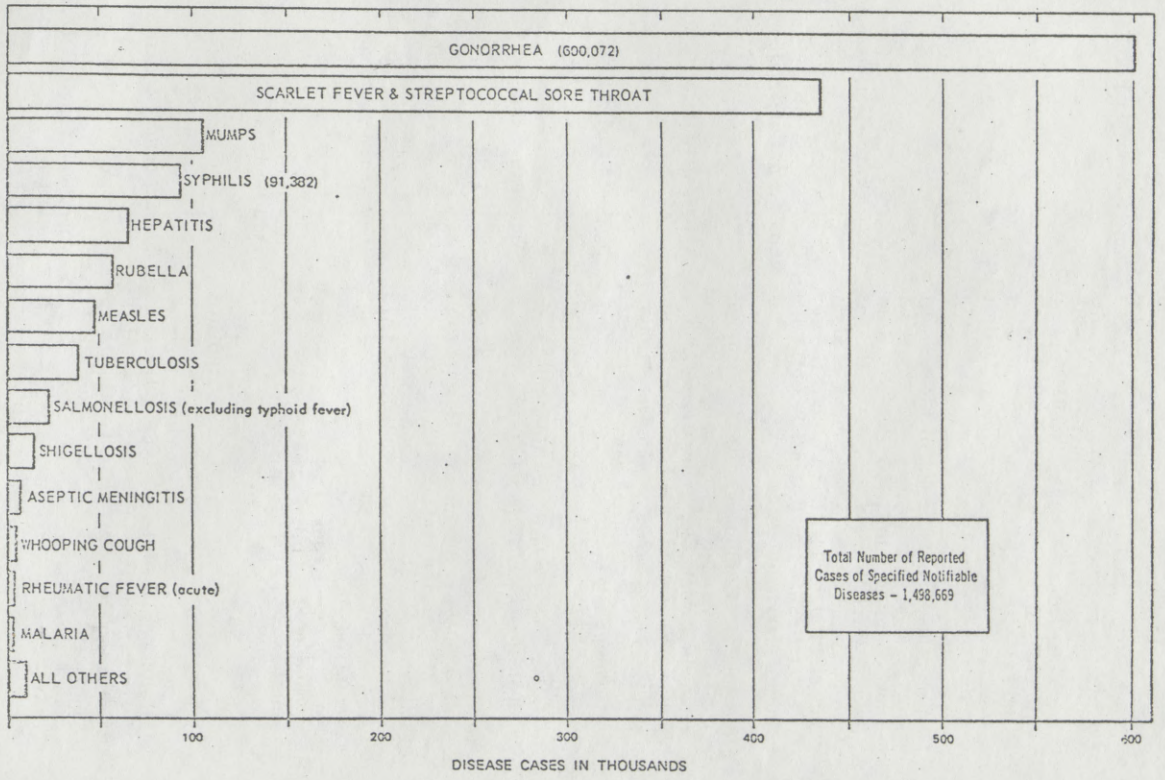
Chairman: Bruce P. Webster, M.D., Emeritus Professor of Clincial Medicine, Cornell University Medical College, 440 E. 68th Street, New York, New York 10021.

Representing: The American Social Health Association.

Members	*Representing*
Edwin J. DeCosta, M.D., Professor, Department of Obstetrics and Gynecology, Medical School, Northwestern, Chicago, Illinois 60611	American College of Obstetricians and Gynecologists.

Harry B. Elmets, D.O. Professor of Dermatology, Chairman, Department of Dermatology, College of Osteopathic Medicine and Surgery, 772 6th Avenue, Des Moines, Iowa 50309	American Osteopathic Association.
Jerome H. Greenberg, M.D., Colonel, MC, Chief, Preventive Medicine Division, OTSG, Department of the Army, Forrestal Building, Washington, D.C. 20314	Department of Defense.
Donald Harter, M.D., Professor of Neurology, Columbia Presbyterian Medical Center, 630 West 168th Street, New York, New York 10032	American Academy of Neurology.
C. A. Hoffman, M.D., President Elect American Medical Association, 800 First National Bank Building, P.O. Box 250, Huntington, West Virginia 25701	American Medical Association.
John C. Hume, M.D., Dean, School of Hygiene and Public Health, The Johns Hopkins University, 615 North Wolfe Street, Baltimore, Maryland 21205	American Public Health Association.
Rudolph H. Kampmeier, M.D., Professor Emeritus, Vanderbilt University, School of Medicine, Nashville, Tennessee 37203	American College of Physicians.
John A. Kenney, Jr., M.D., Professor and Chairman, Division of Dermatology, Howard University, College of Medicine, Washington, D.C. 20001	National Medical Association.
John M. Knox, M.D., Professor and Chairman, Department of Dermatology, Baylor University, College of Medicine Texas Medical Center, Houston, Texas 77025	American Academy of Dermatology.
Gordon R. MacDonald, M.D., Senior Attending Urologist Washington Hospital Center Washington, D.C. 20010	American Urological Association.
Charles H. Miller, M.D., Captain, MC, USN Naval Medical Research Unit No. 4, Great Lakes, Illinois 60088	Department of Defense.
Sam Nixon, M.D., Chairman, Subcommittee on Communicable Diseases, American Academy of Family Physicians, 1303 Hospital Boulevard, Floresville, Texas 78114	American Academy of Family Physicians.
Paul F. Nugent, M.D. Colonel, MC, Chief, Preventive Medicine Branch Aerospace Medicine Division, Office of the Surgeon General, USAF/SGPAAP, Forrestal Building, Washington, D.C. 20314	Department of Defense.
Harry Pariser, M.D., Director, Venereal Disease Control, Norfolk City Health Department 401 Colley Avenue, Norfolk, Virginia 23507	American Venereal Disease Association.
Ralph Spaeth, M.D., Clinical Professor of Pediatrics, College of Medicine, University of Illinois, Chicago, Illinois 60612	American Academy of Pediatrics.
Thomas B. Turner, M.D., Dean Emeritus, The Johns Hopkins University, School of Medicine, 720 Rutland Avenue, Baltimore, Maryland 21205	Association of American Medical Colleges.

COMMUNICABLE DISEASES – NUMBER OF REPORTED CASES
United States, Calendar Year 1970



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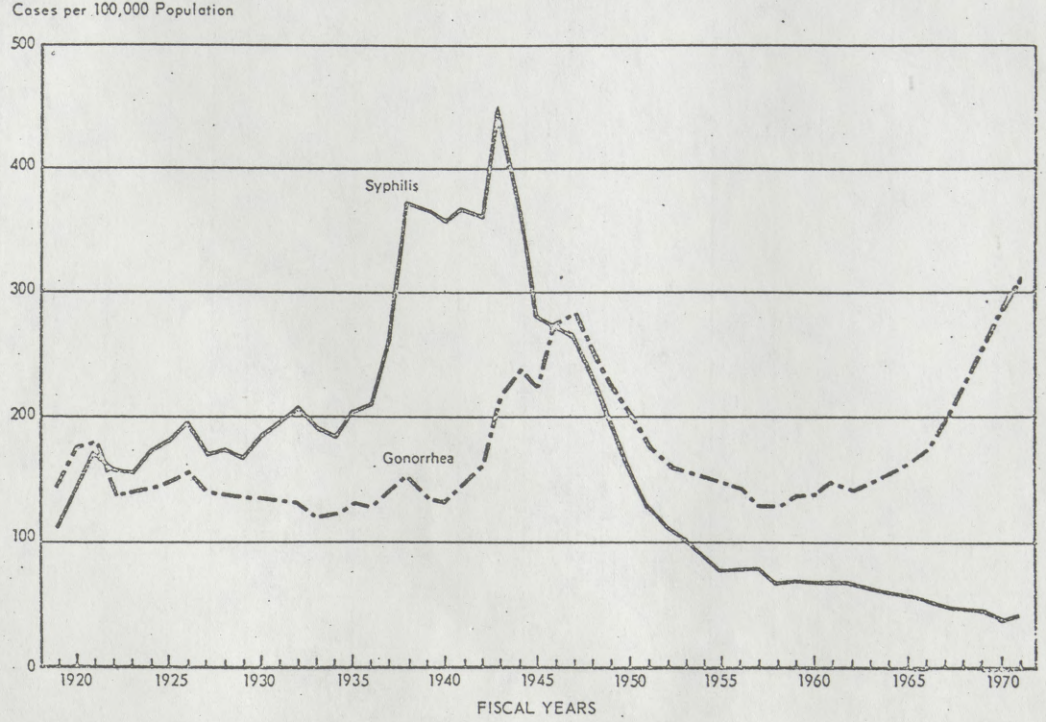
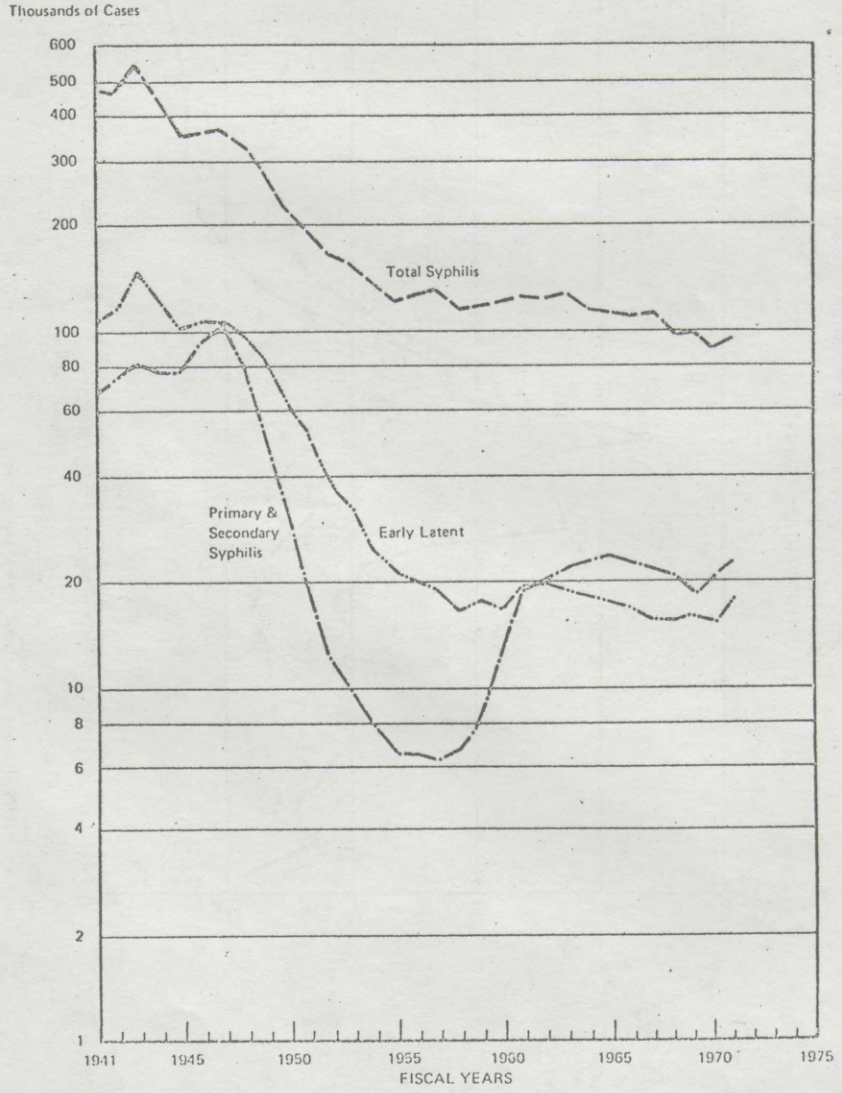
REPORTED SYPHILIS AND GONORRHEA CASES
PER 100,000 POPULATION
UNITED STATES*, 1919-1971

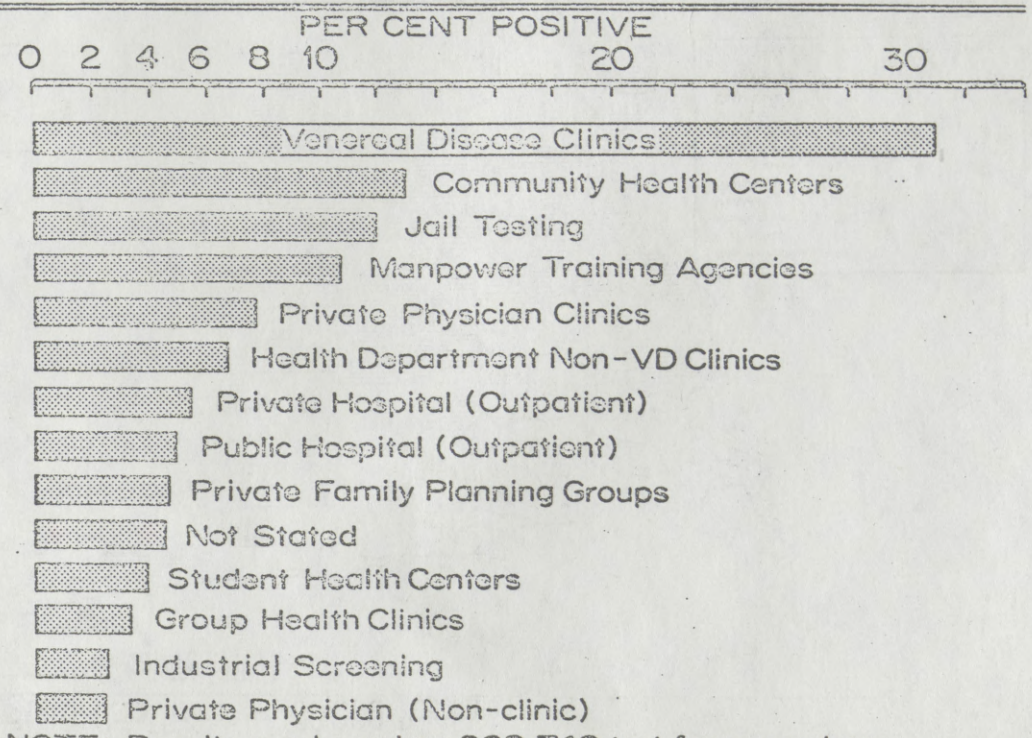


*Beginning in 1939 all states are included in the reporting area
(Military cases included 1919-1940) excluded thereafter)

SYPHILIS
Reported Cases by Diagnosis
United States, 1941-1971



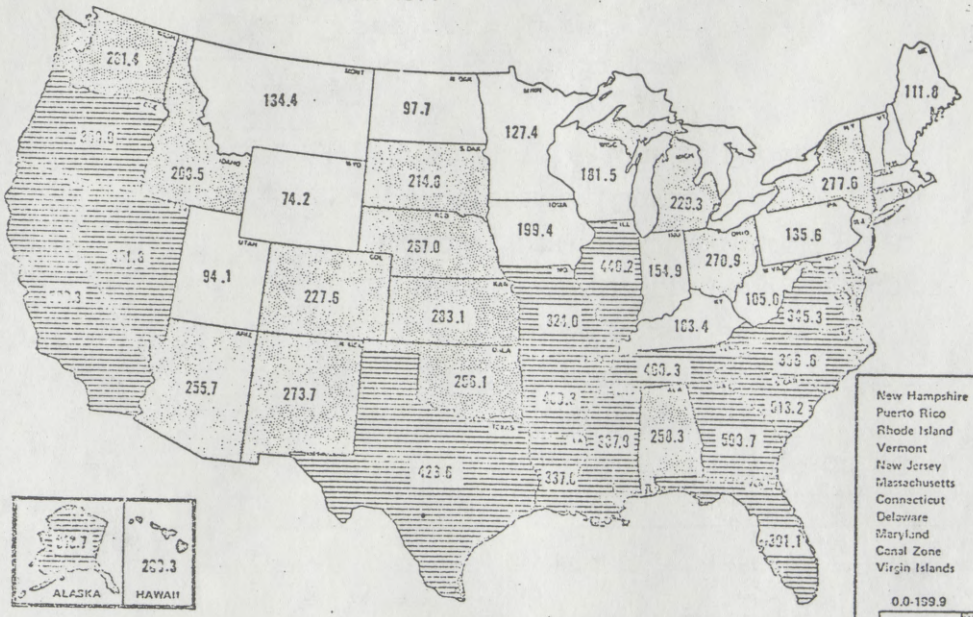
GONORRHEA SCREENING SUMMARY (FEMALES)
% Positive by Type of Facility Performing Test – FY 1970



NOTE: Results are based on 269,749 test for gonorrhea

GONORRHEA

Case Rates per 100,000 Population
Fiscal Year 1971



New Hampshire	72.7
Puerto Rico	79.5
Rhode Island	96.7
Vermont	102.7
New Jersey	143.5
Massachusetts	151.6
Connecticut	213.8
Delaware	283.9
Maryland	372.5
Canal Zone	503.6
Virgin Islands	1136.8

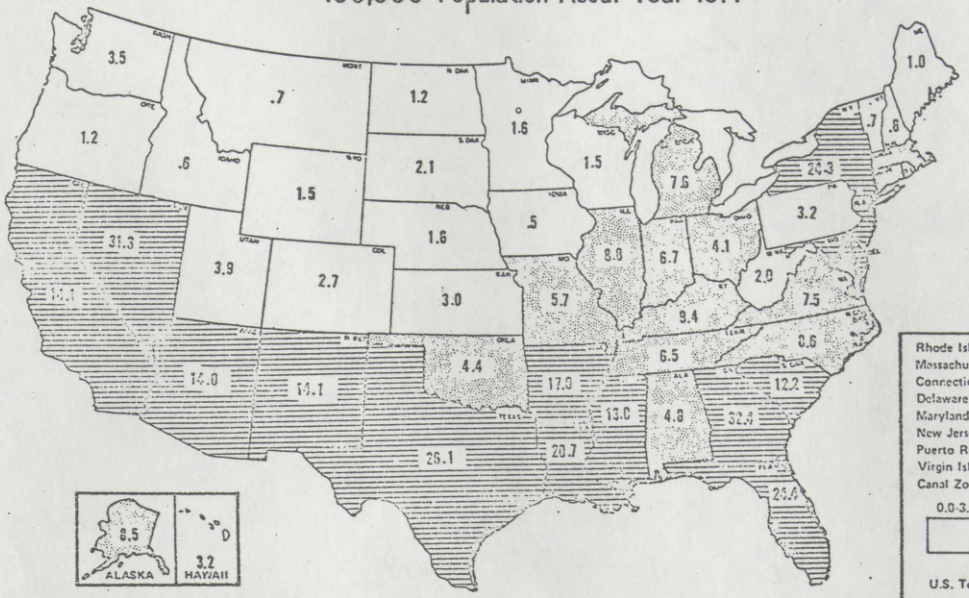
0.0-199.9 | 200.0-299.9 | 300.0-1136.8

U.S. Total	307.5*
Median	257.2**

*U.S. Total includes District of Columbia.

**Excludes Puerto Rico, Virgin Islands, and Canal Zone.

PRIMARY & SECONDARY SYPHILIS Case Rates per 100,000 Population-Fiscal Year 1971

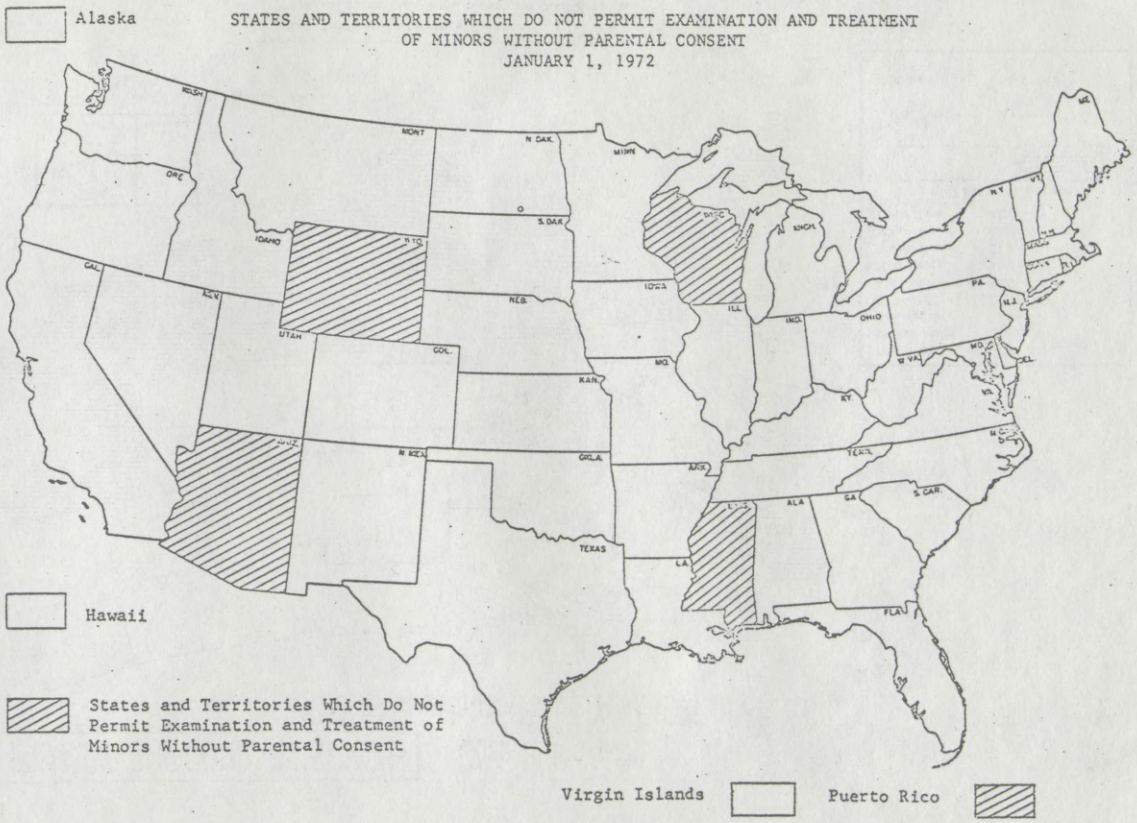


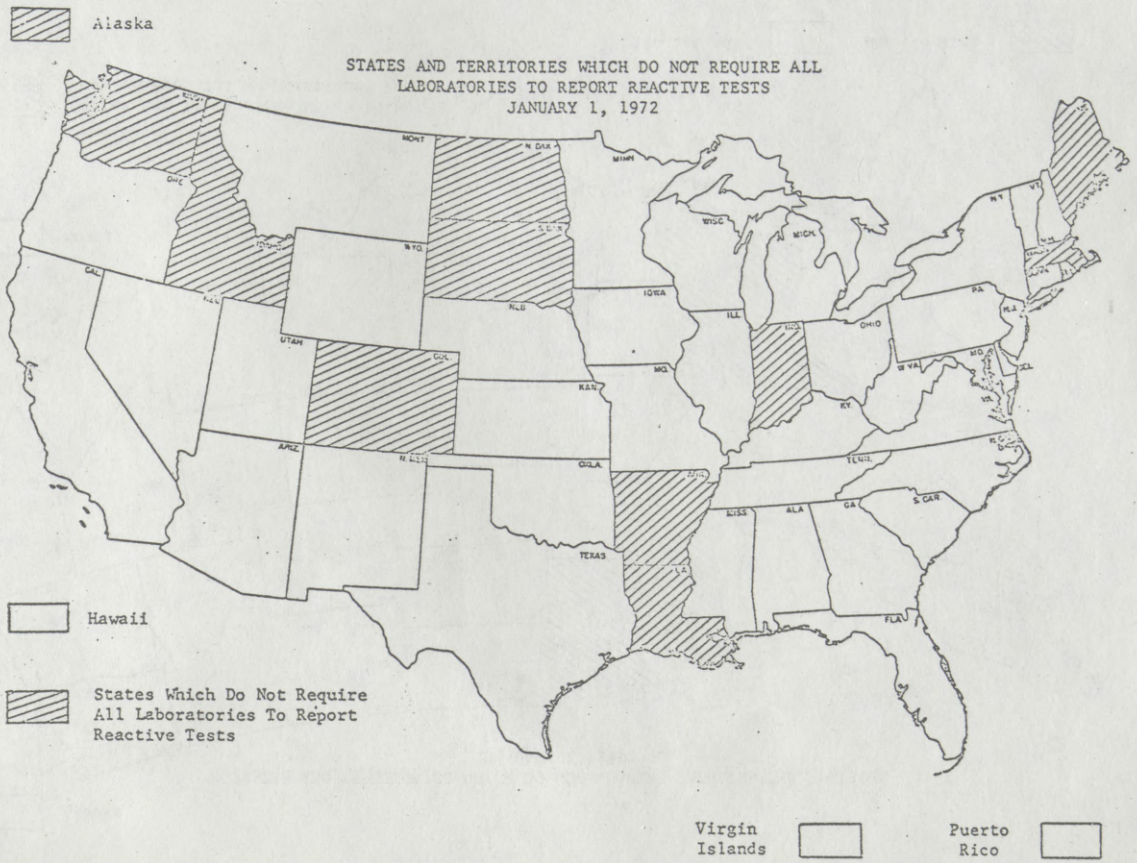
Rhode Island	4.9
Massachusetts	5.5
Connecticut	7.2
Delaware	11.8
Maryland	12.5
New Jersey	14.8
Puerto Rico	31.9
Virgin Islands	43.9
Canal Zone	62.9

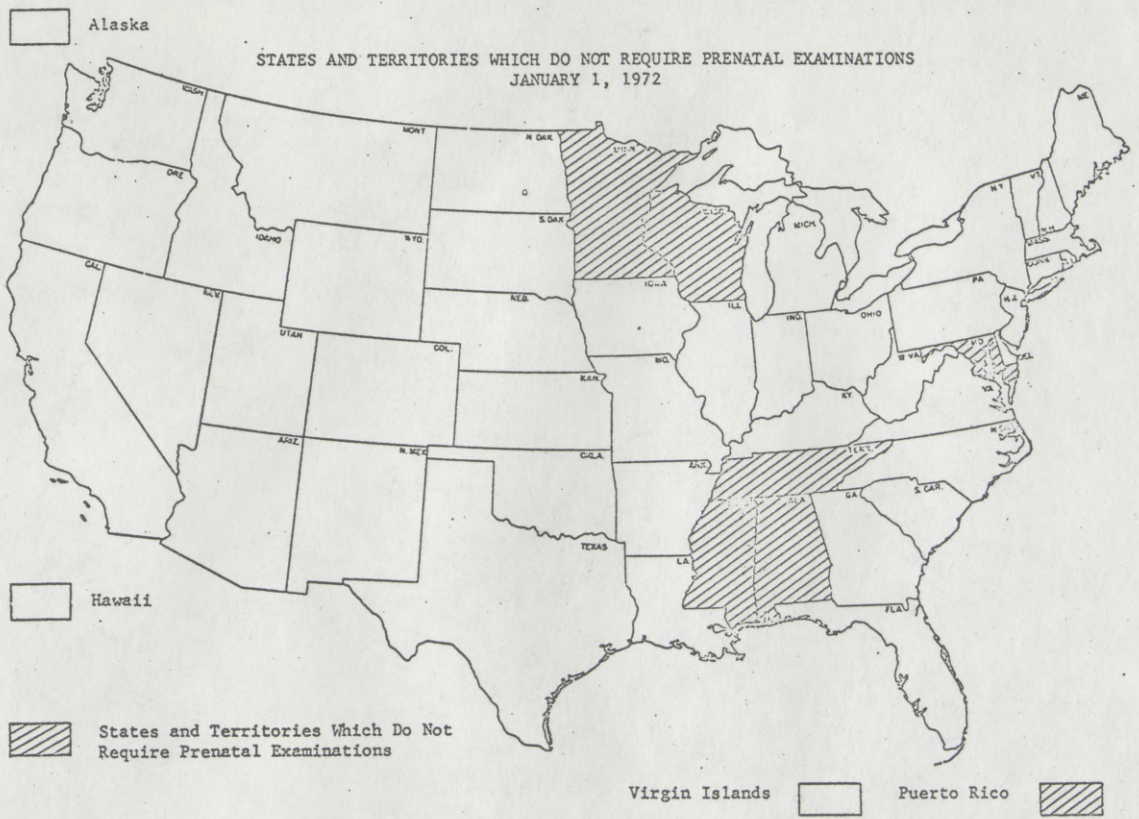
0.0-3.9 4.0-9.9 10.0-62.9

U.S. Total	11.5*
Median	5.6**

*U.S. Total includes District of Columbia.
**Excludes Puerto Rico, Virgin Islands, and Canal Zone.


Alaska
STATES AND TERRITORIES WHICH DO NOT PERMIT EXAMINATION AND TREATMENT
OF MINORS WITHOUT PARENTAL CONSENT
JANUARY 1, 1972
WASH
ORE
CAL
NEV
IDAHO
MONT
N. DAK.
S. DAK.
WYO
UTAH
COL
NEB.
KAN.
N. MEX.
OKLA.
TEXAS
MINN
IOWA
MO.
ARK.
LA.
WIS.
ILL.
MICH.
IND.
OHIO
KY.
TENN.
MISS.
ALA.
GA.
S. CAR.
FLA.
W. VA.
PA.
N.Y.
VT.
N.H.
MASS.
CONN.
R.I.
MD.
DEL.
Hawaii
States and Territories Which Do Not
Permit Examination and Treatment of
Minors Without Parental Consent
Virgin Islands
Puerto Rico


Alaska
STATES AND TERRITORIES WHICH DO NOT REQUIRE ALL
LABORATORIES TO REPORT REACTIVE TESTS
JANUARY 1, 1972
Hawaii
States Which Do Not Require
All Laboratories To Report
Reactive Tests
Virgin
Islands
Puerto
Rico


Alaska
STATES AND TERRITORIES WHICH DO NOT REQUIRE PRENATAL EXAMINATIONS
JANUARY 1, 1972
Hawaii
States and Territories Which Do Not Require Prenatal Examinations
Virgin Islands
Puerto Rico

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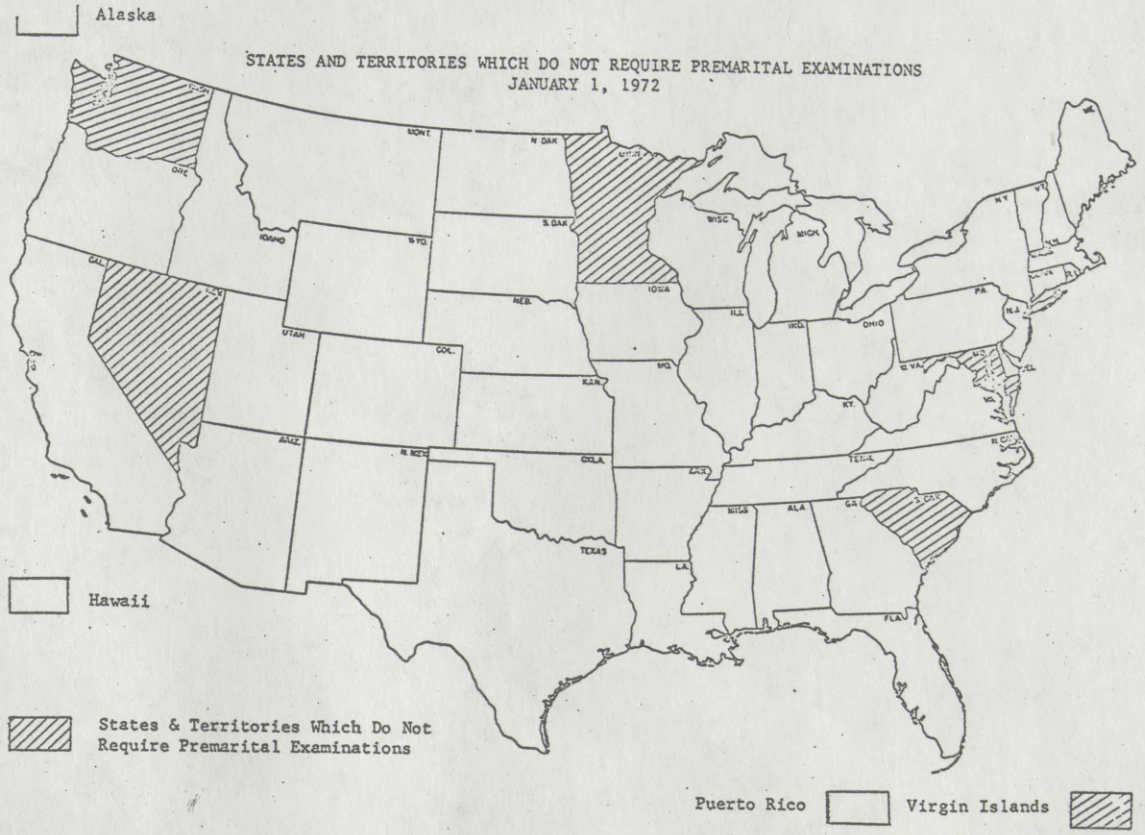
Alaska
STATES AND TERRITORIES WHICH DO NOT REQUIRE PREMARITAL EXAMINATIONS
JANUARY 1, 1972
Hawaii
States & Territories Which Do Not Require Premarital Examinations
Puerto Rico
Virgin Islands

today's VD control problem 1972

ACKNOWLEDGEMENT

"Today's VD Control Problem" is a Joint Statement written and published by the American Social Health Association and co-sponsored by the American Public Health Association, the American Venereal Disease Association and the Association of State and Territorial Health Officers.

Officially cooperating organizations are the American Medical Association, the American Osteopathic Association and the National Medical Association.

The Sponsors of the Joint Statement wish to thank the many people who have made possible the annual publication of the Joint Statement for the past 19 years. Special thanks are extended to the health departments of 160 cities and counties, all the states and the Commonwealth of Puerto Rico for supplying comprehensive information on VD control problems in their areas of jurisdiction; to the Venereal Disease Branch of the Center for Disease Control of the U.S. Public Health Service for assistance with statistics and other material; and to the World Health Organization for supplying information on the venereal disease situation outside the United States.

With this cooperation, the publishers of the Joint Statement have been able to analyze incidence trends of infectious syphilis and gonorrhea on a national, state and community basis; to describe progress towards bringing syphilis and gonorrhea under control; and to make recommendations as to the adequacy of funding and the types of approach government and medicine should take to control the spread of these diseases.

Sponsors

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Department of the Army

ASHA Staff: Geraldine Rasmussen

CONTENTS

RECOMMENDATIONS

In view of the data presented in this Joint Statement, which indicate that reported infectious syphilis cases are increasing at a rate even greater than last year and that reported gonorrhea cases are continuing to increase, the following recommendations are made to federal, state and local governments, the medical profession and voluntary groups:

I. The recommendations of the National Commission on Venereal Disease should be evaluated and implemented as top priorities.

II. The increase of $16 million in federal venereal disease control funds for FY 1972, under Section 317 of the Public Health Service Act (the Communicable Disease Control Amendments of 1970) should be continued. It should be consolidated with the $6.3 million in venereal disease funds now being provided under the authorization of Section 314e of the Public Health Service Act and the total increased for FY 1973.

III. Authorization for extending the availability of the $16 million increase in venereal disease funds and permitting its augmentation, should be made by extending the effective period of Section 317 of the Public Health Service Act. This section should also be changed to include a Research, Demonstration and Training Section which would provide grants for remedying the serious deficiencies now present both in research on the venereal diseases and in undergraduate and graduate education in venereal disease control in medical and public health schools.

IV. Venereal Disease Branch (Center for Disease Control) operating funds should be increased in FY 1973 to insure:

—that CDC provide the leadership, programs and technical assistance necessary to implement and evaluate a new nationwide gonorrhea control effort, and to improve syphilis control and coordination of all activities against the venereal diseases;

—that CDC carry out the federal government's responsibilities in the recommendations which follow.

V. An expanded and coordinated research program should be initiated with funds from federal and other sources which would develop:

—increased research capabilities through pilot projects and training grants;

—improved diagnostic methods for gonorrhea, including both immunologic procedures and cultures;

—knowledge of the extent of the clinical complications of gonorrhea;

—knowledge of mechanisms of resistance of *N. gonorrhoeae;*

—effective topical and systemic chemo-prophylactic agents against venereal disease, a satisfactory vaccine against syphilis, an immunizing agent against gonorrhea;

—knowledge of the human behavioral aspects involved in the spread of venereal disease, particularly in patients with repeated infections.

VI. Schools of medicine and public health should improve and extend their venereal disease research and teaching activities; and medical schools, their care of such cases in teaching hospitals, hopefully assisted by federal grants which would permit a regular faculty member to devote at least half-time to these areas and to assist and encourage other faculty members to participate in them.

VII. The Venereal Disease Branch of CDC should add to its programs:

—a special investigation of the deficiencies of prenatal care, which have resulted in the increase of reported cases of congenital syphilis under one year of age;

—training courses for young physicians to involve more of them in the clinical and control aspects of syphilis and gonorrhea.

VIII. New techniques of venereal disease education, including use of peer group aides, should be developed with federal assistance in order to reach teenagers and young adults more effectively.

IX. The Comprehensive Health Plan for each state should include a plan for venereal disease control, kept constantly up-to-date.

X. State and local governments should make commitments of their own resources for venereal disease control more commensurate with the magnitude of the problem.

XI. Health departments should:

—upgrade public venereal disease clinics by increasing their number and improving their quality;

—explore more extensively the possible advantages of closer association of public clinics with hospitals, particularly teaching hospitals;

—strengthen diagnostic and record keeping procedures in order to improve the accuracy of gonorrhea morbidity statistics, now less complete and accurate than syphilis morbidity statistics;

—press ahead with instituting effective routine interviewing and contact tracing of all gonorrhea patients, giving priority to male patients;

—innovate procedures for contact tracing of gonorrhea patients, including trials of having patients bring in their own contacts, and trials of encouraging private physicians to have contact investigation done on their patients, including prophylactic treatment of contacts, either by health department or their own personnel;

—encourage and facilitate screening cultures for gonorrhea (known to be productive) wherever routine pelvic examinations are done at gynecological, prenatal, family planning and other clinics, as well as in private medical offices;

—take steps to insure adequate clinical care and epidemiologic investigation of venereal disease cases handled in hospitals, in the newer clinics, such as OEO, Model Cities, neighborhood and "free" clinics and in the health maintenance organizations now being developed.

XII. Professional associations involved in the National Commission on Venereal Disease should take leadership in improving the care and reporting of that majority group of venereal disease patients—those handled by private physicians.

XIII. The pharmaceutical profession should:

—through its industry give high priority to the development of additional antibiotics effective against *N. gonorrhoeae* to insure keeping ahead of the antibiotic resistance problem;

—through the American Pharmaceutical Association and individual pharmacies increase venereal disease education and awareness.

XIV. The American Social Health Association should carry out a national venereal disease awareness campaign.

XV. Governors, mayors and other state, urban and county leaders should activate committees for increasing awareness of the magnitude of venereal disease problems in their areas.

XVI. Hospitals, clinics and physicians should be made aware of the present attack rate of syphilis so that routine serologic testing will be increased, particularly in high risk groups.

XVII. The jurisdictions (four states and a commonwealth) without laws, regulations or attorney general's rulings, and the jurisdictions (five states) with only attorney general's rulings clearly allowing treatment of minors for venereal diseases without parental consent, should seriously consider their need for passing such legislation or adopting such a regulation. States and territories with laws and regulations permitting such treatment of minors should carefully review their laws or regulations to make certain of their adequacy.

President	American Public Health Association	*Executive Director*
President	American Social Health Association	*Executive Director*
President	American Venereal Disease Association	*Executive Secretary-Treasurer*
President	Association of State and Territorial Health Officers	*Secretary-Treasurer*

PROGRESS REPORT

Reported cases of infectious syphilis continued to climb upward during fiscal year 1971* with a rate of increase twice that of 1970. The successful reduction in incidence achieved during the period 1966-69 was completely obliterated. Accentuating the seriousness of the increase was the fact that casefinding efforts had decreased rather than increased. Gonorrhea also continued to increase, although at a slower rate than in recent years. More cases of infectious syphilis were reported during FY 1971 than in any year since 1950, and gonorrhea was at its highest level on record.

Syphilis control efforts throughout the country during FY 1971 were able, at best, to maintain the program framework needed to control syphilis. No nationwide coordinated effort to control gonorrhea was undertaken, but encouraging results were obtained from special casefinding projects in a number of areas. The year may represent, however, the period during which additional commitments were made to eliminate these public health problems. It is particularly encouraging to report that several of the recommendations made in last year's Joint Statement have received active support, and in a few critical areas implementation, by the policy makers and health practitioners to whom they were directed.

*Fiscal year 1971 is the year July 1, 1970 through June 30, 1971.

I. National Commission

The first recommendation of last year's Joint Statement called for the formation of a National Commission on Venereal Disease. The Commission was appointed on February 4, 1971, by Roger O. Egeberg, M.D., former Assistant Secretary for Health and Scientific Affairs of the Department of Health, Education, and Welfare. Dr. Egeberg stated that "The Commission will consider the problems of syphilis and gonorrhea from a national standpoint, study ways of bringing public health and private medicine into a closer working relationship and make recommendations for bringing these diseases under control. The Commission will make recommendations to the government and to the professional groups which the Commission represents." Bruce Webster, M.D., president of the American Social Health Association, accepted chairmanship of the Commission, and Dr. Egeberg designated the Center for Disease Control in Atlanta to provide staff support for the Commission. Dr. Egeberg requested that the Commission be composed of selected officials of the Armed Forces, the Surgeon General of the Public Health Service and representatives of the following professional associations: American Academy of Dermatology; American Academy of Family Physicians; American Academy of Neu-

rology; American Academy of Pediatrics; American College of Obstetricians and Gynecologists; American College of Physicians; American Medical Association; American Osteopathic Association; American Public Health Association; American Social Health Association; American Urological Association; American Venereal Disease Association; Association of American Medical Colleges; National Medical Association.

The first of four meetings of the Commission was held on April 19, 1971. Committees were set up in five areas: Education and Communication; Basic Research; Operational Research; Funding; and Private Medicine and Public Health.

II. Federal Funding

The recommendation for federal funding in last year's Joint Statement called for total federal appropriations in FY 1972 of $23,865,000. This was approximately $11.7 million more than the total federal funds for VD control in FY 1971 of $6.3 million from Section 314e of the Partnership for Health Legislation and $5.9 million appropriated for the Venereal Disease Branch of the Center for Disease Control.

The House of Representatives Committee on Appropriations recognized the deteriorating situation in VD control and the need for additional federal funds, both of which were highlighted in last year's Joint Statement. It added an additional $10 million for VD and immunization assistance to its Bill for FY 1972. After hearing the testimony of the director of the Center for Disease Control, the committee augmented the increase for VD and immunization to $20 million, to be available on a categorical grant basis, and ear-marked $16 million of the extra funds for VD control. This increase was passed by Congress in the Appropriations Bill.

III. VD Task Forces

An encouraging development was the establishment in a number of states and cities of broadly representative committees to coordinate the forces involved in the comprehensive control of the venereal diseases and determine their appropriations for state and local needs.

IV. Comprehensive Health Plans

The Comprehensive Health Plans of 38 states now include a section on VD control so that the relative priority for this activity can be established.

V. Professional Associations

A number of state and local medical societies have set up VD committees which have helped to stimulate continuing education and cooperation of private physicians with public health departments.

In June, the American Medical Association's House of Delegates adopted a strong resolution closely paralleling the recommendations of the Joint Statement. The AMA made VD and drug abuse the subjects of its Community Health Week, 1971, officially the third week of October. A public education kit was sent to state and county medical organizations and allied health agencies.

The theme of the American Pharmaceutical Association's National Pharmacy Week in October 1971 was "V.D. – Voluntary Disaster."

VI. New Therapeutic Agents

The status of some additional therapeutic agents has been better clarified. Spectinomycin has been released for use in the U.S. and is now the drug of choice for treatment of gonorrhea in penicillin-sensitive individuals.

VIII. Research

Some work on important areas of need, such as a syphilis vaccine and screening tests for gonorrhea, has continued, but progress has been slow.

Noteworthy advances have been the development and improvement of the Transgrow medium to facilitate sending gonorrhea cultures to central laboratories and the development of the FTA-ABS-IgM test for early serologic diagnosis of congenital syphilis in the newborn.

Another encouraging development has been the initiation of serious investigations of chemoprophylactic agents and the possibility of combining chemoprophylactic and contraceptive agents.

A gonorrhea workshop and a meeting on syphilis research were held in 1971 by the National Institutes of Health, which is also planning a meeting on the behavioral aspects of the venereal diseases.

The latest research and clinical experience from both the United States and abroad were presented at an International Venereal Disease Symposium held in St. Louis, Missouri, in April 1971. The symposium was co-sponsored by the American Social Health Association and Pfizer Laboratories Division, Pfizer, Inc.

IX. National VD Awareness Campaign

The need for an organized national awareness pro-

gram was recognized by Pfizer, Inc., which has agreed to underwrite a campaign beginning in 1972, provided the Advertising Council and the American Social Health Association can agree as joint sponsors on details of its production.

A number of VD awareness campaigns were carried out during 1971 in various states and cities.

XI. American Public Health Association Meeting

A section meeting entitled "Epidemiology and Behavioral Aspects of Venereal Disease Control" was included in the program of APHA's 1971 annual meeting. The American Venereal Disease Association sponsored the meeting, which will be an annual event.

XIV. Comprehensive Health Care Programs

Replies to the Joint Statement questionnaire indicate considerable progress in establishing better facilities for VD education and treatment associated with neighborhood health centers, Model Cities programs, family planning clinics, "free" clinics, community OEO centers, migrant health clinics, etc.

XV. Cultures for Gonorrhea in Connection with Routine Pelvic Examinations

Replies to the Joint Statement questionnaire indicate considerably increased efforts to detect asymptomatic gonorrhea in the female, but only sporadic attempts to learn the scope of asymptomatic male gonorrhea. A number of these projects were funded by the Public Health Service. Programs for furnishing gonorrhea culture facilities for the private physician are now under way through such developments as Transgrow medium.

XVII. Treatment of Minors

The number of states with laws permitting minors to give their own consent for VD treatment has increased to 41, in line with last year's recommendation on this subject. The territory of the Virgin Islands and the District of Columbia also have such laws, but Puerto Rico does not.

Five of the nine states without laws do have opinions of their attorneys general permitting minors to be treated without notifying parents. Some of the state laws are not adequate and should be revised.

INCIDENCE & TRENDS

Primary and Secondary Syphilis

Table A shows that for the second straight year reported cases of primary and secondary syphilis have increased. The 23,336 cases reported in FY 1971 represent a 15.6% increase over 1970, nearly twice the increase of FY 1970 over FY 1969. The increase of FY 1971 over FY 1969 is 24.9%. A steady decline from FY 1966 through FY 1969 has now been wiped out, and the number of reported cases is the highest since FY 1950. (See Table II, page 47, and Figure 2, page 48.)

In the first half of FY 1972 (July-December 1971), reported primary and secondary syphilis is 6.1% higher than the same period in FY 1971.

Most of these increases have occurred in the nation's metropolitan areas, although there have been some outbreaks of the disease in less populated areas which had earlier established a level of control. Dwindling federal resources have been gradually shifted to the cities, where the bulk of the problem exists. While this may have resulted in a less precipitous increase in infectious syphilis on a national basis than was anticipated a year ago, it has left many potential reservoirs of disease uncovered. A total of 11 states received no federal project grant support during FY 1971 and several others have had major reductions in federal funds almost immediately after attack rates have fallen.

Despite the shift in federal grant allocations to meet

TABLE A

PRIMARY AND SECONDARY SYPHILIS AND GONORRHEA
Reported Cases and Rates per 100,000 Population

United States, Fiscal Years 1957, 1963-1971

Year	Primary and Secondary Syphilis			Gonorrhea		
	Number of Reported Cases	Rate per 100,000 Population	Percent Change from Previous Year	Number of Reported Cases	Rate per 100,000 Population	Percent Change from Previous Year
1957	6,251	3.8	—	216,476	129.8	—
1963	22,045	11.9	+ 9.8	270,076	145.7	+ 3.7
1964	22,733	12.1	+ 3.1	290,603	154.5	+ 7.6
1965	23,250	12.3	+ 2.3	310,155	163.8	+ 6.7
1966	22,473	11.6	— 3.3	334,949	173.6	+ 8.0
1967	21,090	10.8	— 6.1	375,606	193.0	+ 12.1
1968	20,182	10.3	— 4.3	431.380	219.2	+ 14.8
1969	18,679	9.3	— 7.4	494,227	245.9	+ 14.6
1970	20,186	10.0	+ 8.1	573,200	285.2	+ 16.0
1971	23,336	11.5	+ 15.6	624,371	307.5	+ 8.9

Source: Public Health Service.

the demands of high incidence areas, and some increase in state and local appropriations, syphilis in the cities continued to rise. In cities of more than 200,000 population, reported primary and secondary syphilis increased 24% during FY 1971. Some cities reported even more dramatic increases, as shown in Table B.

TABLE B

PRIMARY AND SECONDARY SYPHILIS AND GONORRHEA

Reported Cases and Percent Increase or Decrease

Selected Metropolitan Areas, Fiscal Years 1970 & 1971

Primary and Secondary Syphilis

Cities	Reported Cases 1970	1971	Percent Change
Baltimore	270	330	+ 22.2
Las Vegas	89	127	+ 42.7
Los Angeles	942	1,411	+ 49.8
Louisville	58	193	+232.8
Memphis	60	136	+126.7
Miami	263	520	+ 97.7
Newark	367	485	+ 32.2
New York	3,124	3,940	+ 26.1
Oakland	88	120	+ 36.4
San Francisco	386	575	+ 47.7
United States	20,186	23,336	+ 15.6

Gonorrhea

Cities	Reported Cases 1970	1971	Percent Change
Birmingham	2,871	3,685	+ 28.4
Chicago	44,367	39,354	— 11.3
Dallas	12,259	14,761	+ 20.4
Dayton	1,530	2,158	+ 41.0
Denver	2,678	3,202	+ 19.6
Indianapolis	4,136	3,866	— 6.5
Kansas City	4,951	6,032	+ 21.8
Los Angeles	41,639	39,987	— 4.0
Memphis	8,706	11,293	+ 29.7
New Haven	1,468	1,895	+ 29.1
New York	37,399	36,562	— 2.2
Oklahoma City	1,739	2,608	+ 50.0
Richmond, Va.	1,928	2,981	+ 54.6
San Diego	3,347	4,396	+ 31.3
San Francisco	15,362	14,592	— 5.0
Washington, D.C.	13,569	11,197	— 17.5
United States	573,200	624,371	+ 8.9

Source: Joint Statement questionnaire

A total of 34 states showed increased rates of primary and secondary syphilis in FY 1971.

Since private physicians treat most of the syphilis cases which come to medical attention and often fail to notify health authorities when a case is seen, the true incidence of syphilis greatly exceeds the number of newly reported infectious cases. Table I, page 46, shows that the estimated actual incidence of primary and secondary syphilis, according to the 1968 National Survey of Venereal Disease Incidence conducted by the American Social Health Association, is nearly four times the number of reported cases.

The Public Health Survey estimates that 80,000 new cases of syphilis actually occurred during FY 1971. Other authorities consider this an underestimate.

Gonorrhea

The most frequently reported communicable disease* continued to increase during FY 1971, although at a somewhat slower rate than in recent years. (See Figure 3, page 49.) The 624,371 cases reported in FY 1971 represent an 8.9% increase over FY 1970, the lowest rate of increase since FY 1966. It is too soon to know whether this diminished rate of increase is significant. A concomitant decrease in the male-female ratio of reported cases may reflect better casefinding efforts and a reduction of the reservoir of asymptomatic gonorrhea in the female.

For the second consecutive year, the percent increase of gonorrhea cases in a number of cities was much higher than the national average. In a few cities with extremely high gonorrhea incidence, the disease showed varying decreases. (See Table B.)

As with syphilis, many cases of gonorrhea are not detected, and many which are detected and treated are not reported. The actual incidence of gonorrhea in FY 1971 is estimated by the Public Health Service at well over two million cases.

Males generally (although not always) develop symptoms of urethral gonorrhea after acquiring the disease and most of them seek medical care. (Rectal and pharyngeal gonorrhea, however, may be asymptomatic and are usually discovered only through contact tracing.) The trend of reported male cases is considered a rough indication of the trend of gonorrhea in males. In FY 1971, reported male gonorrhea increased 6.6%.

Because clinical signs or symptoms are lacking in the majority of women who acquire the disease, its true incidence is far greater than its reported incidence. The 15.5% increase in FY 1971 of reported female cases of

*Figure 1, page 46, shows that in calendar year 1970, gonorrhea accounted for 600,072 of the total 1,498,669 cases of notifiable diseases reported to the Public Health Service.

gonorrhea was probably influenced by intensive female casefinding programs through screening carried out during the year in several cities.

Failure to diagnose gonorrhea and the private physician's failure to report cases are important factors in the continuing epidemic.

Reinfections

The reinfection rate distinguishes between the number of individuals treated and the number of infections treated. A review of the records shows that some persons receive treatment for a venereal disease more than once during the year, particularly for gonorrhea. Thus, the number of different persons treated and reported is less than the number of cases treated and reported.

Since data on reinfections are not available from all, and are complete from only a few state and city health departments, the Joint Statement can do no more than suggest the extent of the reinfection problem.

The reinfection rate for reported primary and secondary syphilis was 1.0% for the 12,702 cases on which such data were available from 32 states and 110 cities. This is somewhat lower than the 1.5% reinfection rate reported in last year's Joint Statement. No reinfections were reported by 21 states and 88 cities responding to the questionnaire.

Among 86,790 gonorrhea cases in four states and 50 cities which kept such records, a reinfection rate of 15.1% was reported. This is slightly higher than the 13.1% rate reported in last year's Joint Statement, but is undoubtedly an understatement. A health department responding to the questionnaire mentioned results of a study which showed that in one city about 29% of all persons treated for gonorrhea had been treated at least one other time in the previous 12 months.

When the 15.1% reinfection rate is applied to over 2,000,000 cases of gonorrhea estimated treated in FY 1971, over 302,000 appear as reinfections. Population case rates for gonorrhea are therefore misleading.

High reinfection rates reflect the futility of treating the patient without also treating the source of his infection. He may even be reinfected by the original source. New techniques designed to motivate patients to take an active part in bringing their sex contacts to medical examination are being investigated. Effectively involving patients in casefinding and case prevention is an essential aspect of gonorrhea control.

"Other" Syphilis

For epidemiologic and clinical reasons syphilis has been classified in the following sequential stages: primary, secondary, latent and late syphilis. The primary and secondary stages are usually over within six months to a year after the disease has been acquired. It is during these symptomatic stages that the disease is highly infectious and easily spread by means of close, usually sexual, contact. After the early lesion stages are over, an infected person enters the latent stage, during which there are no outward manifestations of the disease and it is detected only by a serologic test. "Early latent" refers to a latent infection of less than two years' duration, and is potentially infectious because recurrences of secondary lesions may occur. "Late latent" refers to infection of more than two years' duration. Late syphilis refers to the development of debilitating manifestations. "Other" syphilis includes those cases of syphilis, which, when diagnosed and treated, were in stages other than primary and secondary, as well as congenital syphilis.

In FY 1971, 23,336 cases of primary and secondary syphilis were reported. There were 71,047 cases of "other" syphilis reported, an increase of 4.9% over the previous year. Of these latter cases, 17,843 were classified as early latent and had been acquired in the previous few years, but had escaped detection. "Other" syphilis cases are mainly discovered through routine serological testing. Approximately 38,000,000 such blood tests are made each year in the U.S.

Another group of syphilis cases is presumed to exist – syphilitic infection which has never been detected. The Public Health Service estimates that there are more than 500,000 persons in the U.S. who have undetected syphilis and are in need of treatment before the disease may progress to destructive neuro-syphilis, cardiovascular, and other serious chronic manifestations. As the incidence of the disease rises, the number of undetected cases may be expected to increase.

Table II, page 47, shows reported cases and rates for all forms of syphilis and for gonorrhea, fiscal years 1950-1971.

A graphic presentation of the trends of reported primary and secondary syphilis and early latent syphilis cases is shown in Figure 4, page 50. The number of early latent syphilis cases reported in FY 1971 exceeded that reported in FY 1970, which suggests that an increasing amount of undetected infectious syphilis is being permitted to progress through the entire infectious stage. This contributes to an increased spread of infection and is a factor in the increase of primary and secondary syphilis reported in FY 1971 and FY 1970. Each person not diagnosed and treated is at risk of disability and death.

Total reported late and late latent syphilis cases decreased from 112,424 in FY 1950 to 84,195 in FY 1960, to 49,537 in FY 1970. The substantial decrease in the past decade is partially due to states' passing and implementing laws and regulations requiring laboratories

to report the results of reactive serologic tests for syphilis to health department officials so that appropriate control measures can be instituted. In 1961, only 12 states had such laws or regulations. By 1971, 39 states and the District of Columbia, Puerto Rico and the Virgin Islands had passed laws or regulations for this purpose.

Trends of late syphilis are primarily determined by control programs in effect from 10 to 20 years ago. Although fewer cases of late syphilis are reported with each passing year, about $40 million in public funds is spent annually for institutional care of the syphilitic insane. About $6 million is spent annually to care for the syphilitic blind.

A total of only 501 deaths due to syphilis were reported during calendar year 1969, the most recent year for which data are available. (An adaptation of the *Eighth Revision International Classification of Disease, Adapted for Use in the United States* came into use in 1968 and 1969, and reported syphilis deaths were reduced by almost 68%.) It should be noted that syphilis is understated as a cause of death because it often is involved in deaths attributed to other causes. Knowledge of a syphilitic cause or a condition may be deliberately withheld. The actual number of deaths due to syphilis is therefore not known.

Congenital Syphilis

Few procedures in preventive medicine are as effective or as inexpensive as the routine prevention of congenital syphilis through serologic testing of pregnant women. And yet there were 2,047 cases of congenital syphilis reported in FY 1971, of which 400, or 19.5%, were diagnosed in the first year of life. This represents not only an increase in the total number of cases over the previous year, but, more significantly, an increase of 33% in the number of cases reported under one year of age. These figures signify a failure on the part of public and private medicine to provide the prenatal care which could have prevented each case.

In 44 states and the District of Columbia, physicians are required to perform a serologic test for syphilis on all pregnant women in their care. Serologic tests in both first and third trimesters are recommended so that women who acquire syphilis during pregnancy do not transmit it to the unborn child. Replies to the Joint Statement questionnaire from 35 counties and cities show that less than 50% of pregnant women in their jurisdictions received STS during both first and third trimesters of pregnancy.

Replies from 61 counties and cities which reported 254 cases of congenital syphilis under one year of age in FY 1971 indicated that 36% of the mothers had received prenatal care. Twenty-two counties and cities reporting one or more cases of congenital syphilis under one year of age could not give information on prenatal care of the mothers. Five of these 22 counties and cities were located in states which do not have prenatal examination laws.

To the question, "Do you routinely follow-up on some or all children born to women who have had a positive STS during or soon after pregnancy" a total of 137 counties and cities replied as follows: 124 Yes; 13 No. Many health departments commented that there were established routines to follow such cases. These varied considerably in detail. Only a few replies referred to the new IgM tests which have been found to be more specific than regular STS in the diagnosis of early congenital syphilis.

TABLE C

CONGENITAL SYPHILIS

United States, Fiscal Years 1962-1971

Number of Cases Reported

Fiscal Year	Total	Under One Year of Age	
		Number	Percent
1962	4,085	330	8.1
1963	4,140	410	9.9
1964	3,737	374	10.0
1965	3,505	373	10.6
1966	3,464	370	10.7
1967	3,050	398	13.0
1968	2,596	327	12.6
1969	2,224	277	12.5
1970	1,903	300	15.8
1971	2,047	400	19.5

Source: Public Health Service

Last year's Joint Statement recommended that the Center for Disease Control of the Public Health Service initiate a program of detailed study of all reported cases of congenital syphilis under one year of age, in order to determine why they were not prevented. The continuing need for such a study is confirmed by replies to the Joint Statement this year.

We can anticipate further increases in congenital syphilis among infants as a result of the recent rise in primary and secondary syphilis.

Routine serologic tests on all pregnant women should be required by law in every state and already existing

laws must be more rigorously enforced. Such a basic public health procedure costs the community far less than medical care of congenital syphilitics, many of whom require institutional care.

Demographic Distribution of Cases

Tables D through F show how reported cases of syphilis and gonorrhea are concentrated in urban areas. Counties and cities included in the tables are listed by name and ranked by rates per 100,000 population in Tables V and VI, pages 55 and 56. Conclusions based on a review of reported cases must be qualified, since we have no demographic information on three fourths of the cases which actually occur in the U.S.

Data in Table D show that 154 counties and cities with 38.2% of the U.S. population accounted for 74.0% of primary and secondary syphilis cases reported during FY 1971. Fifteen of these counties and cities had 45.9% of the reported cases. Only one health department (Chautauqua County, N.Y.) among those surveyed reported no cases of infectious syphilis during the year. (Eight health departments had reported no cases in FY 1969, and four in 1970.)

TABLE D

PRIMARY AND SECONDARY SYPHILIS
Reported Incidence in 154 U.S. Counties and Cities

Fiscal Year 1971

	Rate per 100,000 Population	Number of Counties and Cities	Percent of U.S. Population	Percent of U.S. Cases
	40.0+	15	8.9	45.9
	20.0-39.9	21	6.1	14.2
	11.5-19.9	22	3.6	4.7
	5.0-11.4	46	9.8	6.7
	2.0-4.9	28	7.5	2.3
	0.0-1.9	22	2.3	0.2
Total	22.3	154	38.2	74.0

National Primary and Secondary Syphilis Rate: 11.5

(Fifty-eight cities above national rate include 18.6% of population and 64.8% of U.S. cases.)

(Ninety-six cities below national rate include 19.6% of U.S. population and 9.2% of U.S. cases.)

Source: Joint Statement questionnaire

According to Table F, the rate per 100,000 population for primary and secondary syphilis in cities with over 1,000,000 inhabitants was 2.6 times greater than the national rate. Sixty percent of total U.S. reported infectious syphilis is concentrated in cities with over 500,000 inhabitants.

Table E shows that in FY 1971, 70.5% of reported gonorrhea occurred in 150 counties and cities having only 37.4% of the U.S. population. Thirty-two of these counties and cities reported 46.2% of total U.S. cases.

TABLE E

GONORRHEA
Reported Incidence in 150 U.S. Counties and Cities

Fiscal Year 1971

	Rate per 100,000 Population	Number of Counties and Cities	Percent of U.S. Population	Percent of U.S. Cases
	700.0+	32	13.7	46.2
	400.0-699.9	36	7.6	12.7
	307.5-399.9	24	5.3	5.9
	100.0-307.4	35	6.4	4.5
	0.0-99.9	23	4.4	1.2
Total	580.5	150	37.4	70.5

National Gonorrhea Rate: 307.5

(Ninety-two cities above national rate include 26.6% of U.S. population and 64.8% of U.S. cases.)

(Fifty-eight cities below national rate include 10.8% of population and 5.7% of U.S. cases.)

Source: Joint Statement questionnaire

The epidemic proportions of gonorrhea are illustrated by data in Table VI, page 56, which show that 134 out of 156 areas surveyed had reported rates in excess of 100 per 100,000 population. Twenty counties and cities reported gonorrhea rates in excess of 1,000 infections per 100,000 population.

It should be emphasized, however, that reported case totals are influenced by at least two factors other than the actual attack rate of the disease. Casefinding and educational programs result in a greater percentage of cases being reported among those actually occurring, as does the availability of public health services in a given area. Reporting by public clinics is much more complete than by private physicians, who are the principal, and in many non-urban areas the only, source of venereal disease diagnosis and treatment.

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TABLE F

PRIMARY AND SECONDARY SYPHILIS AND GONORRHEA
Demographic Distribution of Reported Cases

Fiscal Year 1971

PRIMARY AND SECONDARY SYPHILIS

Number of Counties & Cities	Range of Population	Percent of U.S. Reported Cases	Percent of U.S. Population	Rate per 100,000 Population
16	1,000,000+	39.6	15.5	29.5
31	500,000-1,000,000	20.4	10.0	23.4
62	200,000-500,000	9.9	9.5	11.9
45	100,000-200,000	4.1	3.2	1.5
Total 154		74.0	38.2	22.3

National Primary and Secondary Syphilis Rate: 11.5

GONORRHEA

Number of Counties & Cities	Range of Population	Percent of U.S. Reported Cases	Percent of U.S. Population	Rate per 100,000 Population
16	1,000,000+	30.3	15.4	603.2
29	500,000-1,000,000	23.4	9.5	760.1
60	200,000-500,000	11.8	9.2	392.7
45	100,000-200,000	5.0	3.2	481.8
Total 150		70.5	37.3	580.5

National Gonorrhea Rate: 307.5

Source: Joint Statement questionnaire

TABLE G

PRIMARY AND SECONDARY SYPHILIS AND GONORRHEA
Morbidity and Age-Specific Rates per 100,000 Population by Age Groups of Reported Cases

United States, Calendar Year 1970

	Primary and Secondary Syphilis		Gonorrhea	
Age Group	Number of Reported Cases	Rate per 100,000 Population	Number of Reported Cases	Rate per 100,000 Population
0-9	29	0.1	2,226	5.7
10-14	225	1.1	5,289	25.5
15-19	3,651	20.1	147,952	808.6
20-24	6,213	41.9	239,466	1,615.5
25-29	4,424	34.0	110,001	845.6
30-39	4,808	21.7	69,517	313.6
40-49	1,866	7.7	19,267	79.1
50+	766	1.6	6,354	12.9
	Total 21,982	10.9	600,072	297.5

Source: Public Health Service

Geographic Distribution of Cases

Wide variations in reported cases of venereal disease characterize the geographic distribution of the problem. However, *some of these differences in reported venereal disease rates reflect differences in casefinding activity and availability of public clinics, rather than just differences in attack rates.* State rates for primary and secondary syphilis and gonorrhea are ranked in Tables III and IV on page 51 and shown on the maps on pages 52-54.

Reported rates per 100,000 population of primary and secondary syphilis among states for FY 1971 ranged from a low of 0.5 in Iowa to 32.4 in Georgia. Alaska reported the highest gonorrhea rate of 913.7 cases per 100,000 population in FY 1971, and New Hampshire the lowest of 72.7.

Variations among states in the number of cases reported are even greater than variations in rates. Primary and secondary syphilis cases reported by states in FY 1971 ranged from a low of three cases in Vermont to 4,404 cases in New York, while reported cases of gonorrhea ranged from a low of 244 in Wyoming to 97,850 in California. There were no states reporting zero cases.

Distribution of Cases by Sex

States and cities which responded to the Joint Statement questionnaire reported cases of venereal disease by sex as follows:

	Number of States	Reported Cases Male	Female	Ratio Male	Female
P&S Syphilis	(48 + P.Rico)	15,387 :	7,918	1.9 :	1
"Other" Syphilis	(46 + P.Rico)	33,009 :	30,876	1.1 :	1
Gonorrhea	(46 + P.Rico)	306,792 :	118,955	2.6 :	1

	Number of Counties and Cities	Reported Cases Male	Female	Ratio Male	Female
P&S Syphilis	(140)	10,748 :	5,107	2.1 :	1
"Other" Syphilis	(131)	15,072 :	13,310	1.1 :	1
Gonorrhea	(123)	279,648 :	103,999	2.7 :	1

Note: Part of city data included in state totals.

Since external, noticeable symptoms of *primary and secondary syphilis* are more common in males, the male-female ratio of reported cases is largely attributable to the presence of hidden symptoms in women.

The category above, "States," showed that the ratio of male-female reported cases of primary and secondary syphilis was nearly two to one. In "Counties and Cities" the ratio was slightly greater than two to one. The male-female ratio is nearly equal for *"other" syphilis,* in which symptoms have no diagnostic significance. This suggests that the infection rate for primary and secondary syphilis is actually about equal for both sexes, or that more males are treated in the primary and secondary stages, while more females progress to the "other" stage.

When venereal disease control programs include extensive contact interviewing, routine blood testing, and preventive treatment of persons exposed to syphilis, the hidden reservoir of female primary and secondary syphilis will be found and treated. Unfortunately, restricted funds have led to the curtailment of casefinding and case prevention programs.

A male-female ratio of 2.6:1 cases reported by "States" and 2.7:1 reported by "Counties and Cities" is an indication that there is a very large reservoir of undetected *gonorrhea* among females. Symptoms of gonorrhea are usual in male cases, and lack of symptoms usual in female cases. The ratio for male-female gonorrhea this year represents a decrease from the 3.1:1 for "States" and 3.2:1 for "Counties and Cities" shown in last year's Joint Statement. This change may reflect utilization of a more convenient diagnostic test for gonorrhea in the female (Thayer-Martin or Transgrow medium) and some increase in gonorrhea casefinding programs.

Another possible factor in the wide ratio of male to female cases is that infected males are believed to spread gonorrhea to females more readily than females to males. A large asymptomatic female reservoir of disease has been documented by recent pilot gonorrhea screening programs. See Figure 9, page 60.

Such wide disparity between the number of male and female cases reported with gonorrhea illustrates the need for extensive casefinding programs designed to identify asymptomatic females.

Distribution of Cases by Age Group

Reported incidence of primary and secondary syphilis and gonorrhea increased in all age groups of the population between calendar year 1969 and 1970, with one exception. The 0-9 age group, with a consistently low attack rate, had three fewer cases of primary and secondary syphilis reported in 1970 (29) than in 1969 (32).

It must be emphasized that any analysis of age-specific distribution of cases is based on reported cases only, which represent only one fourth of cases actually occurring. Private physicians, who treat most of the unreported cases, may tend to report some age groups more frequently than others.

Review of calendar year 1970 figures in Table G, which contains information on age-specific morbidity

TABLE H

VENEREAL DISEASE SEX CONTACTS CLASSIFIED BY TYPE OF EXPOSURE

Fiscal Year 1971

Primary and Secondary Syphilis Sex Contacts Reported by 32 States and 106 Counties and Cities

Type of Exposure	States		Counties and Cities	
	Number	Percent	Number	Percent
Single Exposure of Opposite Sex	3,240	22.8	2,972	16.4
Multiple Exposure of Opposite Sex	7,680	54.2	8,561	47.2
Single Exposure of Same Sex	799	5.6	1,332	7.3
Multiple Exposure of Same Sex	1,263	8.8	2,933	16.2
Marital Partner	1,219	8.6	2,337	12.9
Sub-total	14,201	100.0	18,135	100.0
Unknown	78		64	
Total	14,279		18,199	

Gonorrhea Sex Contacts Reported by two States and 31 Counties and Cities

Type of Exposure	States		Counties and Cities	
	Number	Percent	Number	Percent
Single Exposure of Opposite Sex	229	67.1	4,946	55.3
Multiple Exposure of Opposite Sex	87	25.5	2,351	26.3
Single Exposure of Same Sex	3	0.9	208	2.3
Multiple Exposure of Same Sex	5	1.5	136	1.5
Marital Partner	17	5.0	1,304	14.6
Sub-total	341	100.0	8,945	100.0
Unknown	69		551	
Total	410		9,496	

Source: Joint Statement questionnaire

and rates for reported cases of primary and secondary syphilis and gonorrhea, shows that the rate of primary and secondary syphilis per 100,000 population was highest in the 20-24 age group (41.9) and nearly four times higher than the national rate (10.9).

The 25-29 age group rate of 34.0 for primary and secondary syphilis and the 30-39 age group rate of 21.7 were significantly high, as was the 15-19 age group rate of 20.0. (See Figure 8, page 59.)

Gonorrhea rates are also highest in the 20-24 age group (1,615.5), about twice the rate of the 25-29 age group (845.6) and the 15-19 age group (808.6). These rates are extremely high and represent rapid increases in reported cases in recent years. For example, in calendar year 1966 the 15-19 age group gonorrhea rate was 436.1.

In calendar year 1970, there were 5,289 cases of gonorrhea reported in the 10-14 age group and 2,226 reported in the 0-9 age group, nearly double the cases reported in 1966.

Tables VII and VIII on page 57 rank state rates per 100,000 population for primary and secondary syphilis and gonorrhea in the 15-19 year age group. Tables IX and X present the same information for the 20-24 year age group.

Distribution of Cases by Race

All reported figures indicate a higher incidence of both syphilis and gonorrhea in non-whites than in whites. This has led many to conclude that venereal diseases are more common among non-whites. The Committee on the Joint Statement does not believe that we have accurate data on this point.

Venereal diseases are notoriously under-reported by private physicians, but are nearly completely reported by public clinics. The socio-economically deprived (of whom non-whites comprise a disproportionate segment) tend to seek medical care from public clinics and are far more likely to be reported than those treated by private

physicians. Consequently, there is considerable bias reflected in the higher reported incidence rate among nonwhites.

Sex Contacts

Health officers were asked to classify sex contacts to a venereal disease by type of exposure: single exposure; multiple (two or more) exposures; and marital partner exposure. The results are tabulated in Table H.

Over 70% of syphilis contacts named were either marital or multiple exposures – a group of contacts that should be fairly easily identified and located through the contact interview and use of the patient's knowledge about his contacts. In contrast, nearly 60% of gonorrhea contacts named were single exposures, which would include casual encounters, pick-ups and prostitutes – contacts difficult to locate since the patient can often supply little or no information about them.

New techniques are needed to bring large numbers of gonorrhea contacts to examination and treatment.

Venereal Disease among Military Personnel

Reported incidence of venereal disease among military personnel serving within the U.S. differs little from civilian rates for equivalent age and sex groups, according to Public Health Service data.

The "Seven Point Agreement of 1967" provided for means of cooperation between military and civilian authorities in venereal disease control. Replies to this year's questionnaire indicate that military installations and most state health departments continue to work together. Meetings and consultations between civilian and military authorities designed to improve this cooperation were reported by 47 states, the District of Columbia and Puerto Rico.

In FY 1971 a total of 252 military installations within the U.S. reported 648 cases of primary and secondary syphilis and 33,104 cases of gonorrhea to civilian health departments, according to replies to the Joint Statement questionnaire. These figures show a 19.3% increase in the number of reported military infectious syphilis cases as compared with the previous year. Reported cases of gonorrhea showed a slight decrease.

The percentage of military patients with infectious syphilis who were interviewed by civilian health department personnel for contact information decreased from 65.9% in FY 1970 to 50.6% in FY 1971, according to replies received on the questionnaire for the Joint Statement. However, the Armed Forces do interview all patients known to have a venereal disease.

Another cooperative effort between military and civilian authorities 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 members of the Armed Forces who acquired an infection while in another area. In FY 1971, 30 state health departments reported that they had received 3,954 reports from military jurisdictions in other states.

Very high infection rates have been reported among military personnel serving in some areas overseas, as illustrated by the following table:

TABLE I

U.S. ARMY INCIDENCE OF VENEREAL DISEASE BY GEOGRAPHIC AREA

Rates per 1,000 Population, Reported Cases Only

Calendar Year 1970

Worldwide	98.5
Continental United States	36.1
Europe	17.3
Japan	27.2
Ryukyus	162.0
Korea	388.5
Thailand	545.5
Vietnam	233.0
Southern Command	74.2

Source: U.S. Army Data

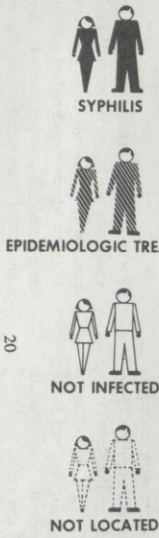
Outbreaks of Venereal Disease

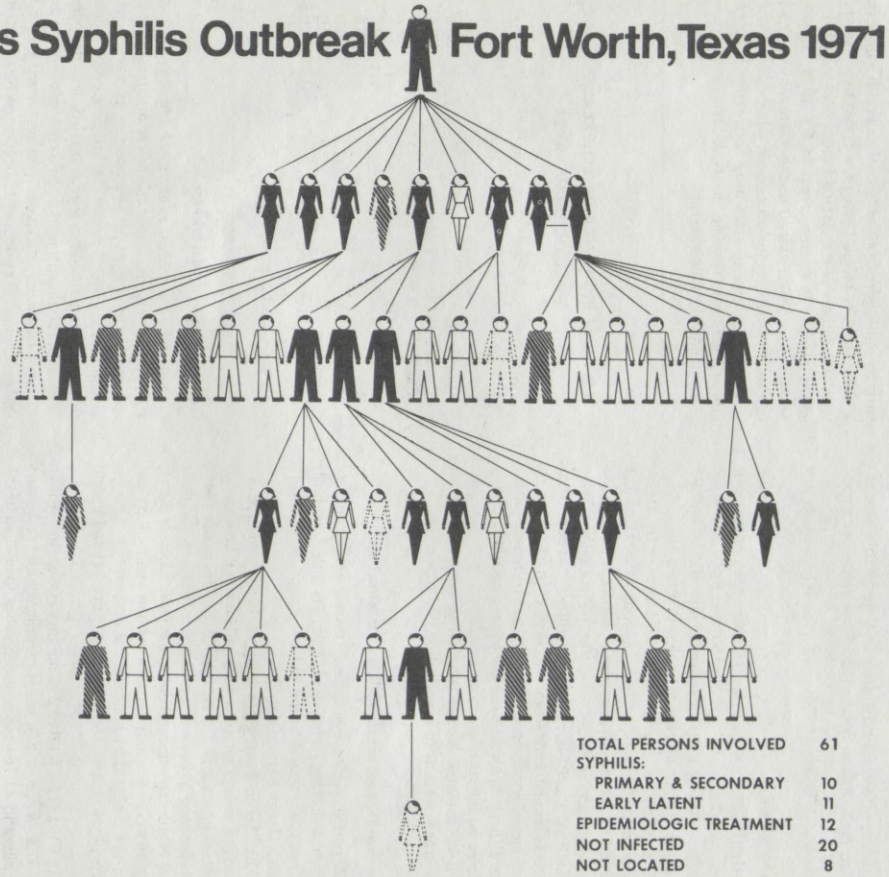
Outbreaks are defined as chains of infection involving 10 or more persons. These chains are discovered by the consecutive tracing of all sex contacts of each person involved. They are "broken" by bringing every contact to examination and treatment as needed. It is the policy of most health departments 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 chart on page 20 portrays such an outbreak, which was reported to the Joint Statement as follows:

> "Fort Worth, Texas, experienced an outbreak of early syphilis during January-March 1971. During the intensified epidemiologic effort that resulted, the longest chain which was identified included 21 cases of early syphilis. The index case was a 24-year-old male who named nine female contacts, seven of whom were infected. Before investigation was complete, a total of 61 persons were involved in the chain."

Infectious Syphilis Outbreak Fort Worth, Texas 1971





TOTAL PERSONS INVOLVED	61
SYPHILIS:	
PRIMARY & SECONDARY	10
EARLY LATENT	11
EPIDEMIOLOGIC TREATMENT	12
NOT INFECTED	20
NOT LOCATED	8

Other outbreaks reported include the following:

"The index case in an outbreak of gonorrhea in Modesto, California, was a 13-year-old female who named 35 male contacts, 20 of whom were infected with gonorrhea. Their ages ranged from 12 to 20 years."

"A chain of 20 cases of early syphilis (six primary, 10 secondary, four early latent) was treated in northeastern Mississippi during FY 1971. The chain included 92 contacts and 48 cluster suspects and associates (terms defined in the section titled *Contact Investigation* on page 25.) This outbreak was predominantly homosexual in origin, with only three cases diagnosed among the female contacts. Thirteen of these cases were determined to be spread cases from one individual."

CONTROL MEASURES

Syphilis and gonorrhea, because of their mode of spread, have wide social as well as medical implications. Their control requires more than a simple doctor to patient relationship. In no community in the world have these diseases been brought and kept under control without a well developed technical strategy involving close cooperation between public health services and medical care facilities, both public and private.

Organization of Health Services

In the U.S., organization of health services is a local community responsibility with assistance provided by state and federal sources. To ensure national uniformity, guidelines are developed at state and federal level for implementation locally through grants in aid.

Clinical and epidemiological patterns of gonorrhea and syphilis differ considerably, even though their mode of transmission is similar. Programs for the control of venereal diseases must reflect these differences. An effective public health methodology for the control of syphilis has been evolved over the years, which, if rigorously applied at community level, could reduce the disease to an insignificant level.

Efforts to control the gonorrhea epidemic are complicated because the disease is undergoing change and the clinical spectrum of involvement includes foci not only in the genital area but also the rectum and pharynx. Strains of the organism have developed which are relatively resistant to penicillin and some other antibiotics and are giving rise to a percentage of treatment failures and persistent infectivity. Serious clinical complications of the disease are appearing in increasing numbers. Technical strategy and programming to combat the present outbreak are lagging behind the adaptability of the organism and the changing pattern of society.

Reporting to public health authorities of syphilis and gonorrhea cases treated by private physicians is mandatory by law in all states. According to the 1968 National Survey of Venereal Disease Incidence, approximately four out of five cases of venereal disease were treated by doctors in private practice, who only reported one out of every nine infectious cases treated. The physician mistakenly believes himself to be in a dilemma between the confidential doctor-patient relationship and his community responsibility. When cases of infectious syphilis occur in areas with well organized epidemiological services that supply confidential contact tracing support to the physician and his patient, failure to report cases is most regrettable.

There are three levels of organized action for control of venereal diseases: federal, state and local. The federal government gives grants in aid to states and local communities for venereal disease control services. These subsidies have been given in the form of categorical grants. (The tendency to over-categorize such grants and to separate syphilis and gonorrhea control is unfortunate.)

Some support is now provided through the Comprehensive Health Plan and the formula grant section (314d) of Partnership for Health legislation, although most states have continued to receive project grants under this legislation (314e) which have been "ear-marked" for syphilis control programs. A total of 11 states, however, did not receive these special project grants for FY 1972. Federal support of venereal disease control in these states is limited to formula grant funds provided for broad health purposes, plus technical assistance, including loaned personnel, from the Public Health Service.

Federal technical leadership is exerted through the Venereal Disease Branch of the Center for Disease Control, U. S. Public Health Service. The CDC conducts research and supplies technical staff to states and local communities on request. Activities of the CDC have been limited in the last three years by financial cutbacks and lack of research manpower interested in the venereal disease problem.

Under Comprehensive Health Planning in Partnership for Health legislation the responsibility has passed to states to allocate formula grant funds according to priorities. However, health planning technology has not yet evolved enough to be able to measure the competing demands upon the health dollar and allocate funds in ac-

cordance with priorities based upon such measurements. No state has yet produced an effective venereal disease control program within the context of its state comprehensive health plan. Funds for venereal disease control at state level have tended to decrease as the problem has increased. Federal project grant funds from the Partnership for Health legislation have been needed to increase control efforts where the venereal disease problem was greatest.

Community Action

It is at county and city level that the detailed planning of venereal disease control is most vital. Technical leadership by the health officer and his staff can mobilize community resources – public, private and voluntary – toward a consolidated attack upon the present expanding epidemic.

Health departments were asked to describe any new approaches to gonorrhea control tried during the year. A review of their replies suggests that, compared with previous years, a good deal of emphasis was placed upon searching for asymptomatic female gonorrhea in family planning clinics, neighborhood health centers, Model Cities programs, "free" clinics, community OEO centers, migrant health clinics, etc. Health departments in some states provided physicians with Transgrow media. Pilot projects of checking contacts of infected males were also carried out.

This selection of replies from state and local health departments indicates the increasing emphasis placed on new approaches to gonorrhea control in FY 1971:

"We have asked VD patients to bring in their contacts to expedite examination and preventive treatment of such contacts. This seems to work fairly well with the 18-25-year-olds (and the hippies from the Big Sur coast area.) During the teacher's workshop, student leaders were invited to attend. Due to a lack of teachers, these students were trained in fundamentals of VD education. They then conducted rap sessions with their peer group. Results were quite gratifying." (Salinas, California)

"Distribution of condoms to male patients." (Ft. Lauderdale, Florida)

"Practicing physicians and the health department combined efforts to establish a gonorrhea screening program to determine prevalence among asymptomatic females in St. Clair County. The study revealed a high incidence of gonorrhea; 11.5% of patients screened were positive. Contact interviewing by a Public Health Service VD investigator resulted in identification of additional cases." (Michigan)

"As a pilot study, all physicians doing pelvic examinations in one county of the state have been provided Transgrow media for doing gonorrhea cultures at no expense to themselves. Although the study is still in process, almost three percent of these females have had positive cultures for gonorrhea. In a two-month period more cases were reported from these physicians (all female cases) than were reported during the entire calendar year of 1970." (Mississippi)

"Gonorrhea examination of female patients attending public health clinics in St. Louis for reasons other than venereal disease has been done for several months with good results. Approximately 5.6% of patients tested were infected. The Kansas City Health Department and a number of family planning clinics throughout the state are also becoming involved in similar screening programs." (Missouri)

"A state-wide program for gonorrhea cultures has been established by the state department of health for diagnosing asymptomatic gonorrhea in females *and males*. A city-employed gonorrhea investigator was hired to perform epidemiologic follow-up to assure treatment of the positives, and contact tracing." (New Jersey)

" 'Selective Gonorrhea Epidemiology' consists of interviewing both males and females for their contacts and encouraging patients to bring or send in their contacts voluntarily or reach these potential patients by phone or letter, but no field visiting." (Norfolk, Virginia)

"A culture method was used to screen 23,320 women for asymptomatic gonorrhea. Cultures were obtained at four health department clinics and seven cooperating facilities. Highest rate was in subjects examined at the public venereal disease clinic and lowest were from a government hospital clinic and a private practice facility. Economic status was based on area of residence. Highest rates were found in women from the lowest economic levels.

"Methods developed for this pilot study should be applied in community-wide screening programs involving private medical care as well as public health services. Attempts to reverse the rising incidence of gonorrhea infection must start with accurate diagnosis and identification of asymptomatic as well as symptomatic cases." (Seattle, Washington)

TABLE J

STATUS OF STATE LAWS OR REGULATIONS REQUIRING THAT LABORATORIES BE APPROVED BY THE HEALTH DEPARTMENT FOR THE PERFORMANCE OF STS

Fiscal Year 1971

State	Public Health Laboratories	Private Laboratories	Public Hospital Laboratories	Private Hospital Laboratories
Alabama	Premarital	Premarital	Premarital	Premarital
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	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Connecticut	All STS	All STS	All STS	All STS
Delaware	All STS	Premarital	Premarital	Premarital
Florida	All STS	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Georgia	All STS	Premarital	Premarital	Premarital
Hawaii	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Idaho	All STS	All STS	All STS	All STS
Illinois	All STS	All STS	All STS	All STS
Indiana	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Iowa	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Kansas	All STS	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Kentucky	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Louisiana	None	None	None	None
Maine	All STS	All STS	All STS	All STS
Maryland	All STS	All STS	All STS	All STS
Massachusetts	All STS	All STS	All STS	All STS
Michigan	All STS	All STS	All STS	All STS
Minnesota	None	None	None	None
Mississippi	Premarital	Premarital	Premarital	Premarital
Missouri	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Montana	All STS	All STS	All STS	All STS
Nebraska	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Nevada	All STS	All STS	All STS	All STS
New Hampshire	Premarital	Premarital	Premarital	Premarital
New Jersey	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
New Mexico	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
New York	All STS	All STS	All STS	All STS
North Carolina	All STS	All STS	All STS	All STS
North Dakota*	None	None	None	None
Ohio	None	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Oklahoma	All STS	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Oregon	All STS	Premarital-Prenatal	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	None	None	None	None
South Dakota	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
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	No Data	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Virginia	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Washington	Prenatal	Prenatal	Prenatal	Prenatal
West Virginia	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Wisconsin	Premarital	Premarital	Premarital	Premarital
Wyoming	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Puerto Rico	All STS	All STS	All STS	All STS
D.C.	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal

*Premarital STS law became effective July 1, 1971.
Source: Joint Statement questionnaire

Health departments were asked to describe the inclusion of venereal disease diagnostic and treatment activities in newly developed Model Cities programs, poverty area programs and neighborhood health centers. A total of 94 cities and 31 states replied that VD control is included in such programs, with considerable variation in the way it is included and in the extent that facilities of such programs are used. Replies also showed considerable variation in the extent of cooperation between the programs and health departments. Such programs can offer important new areas of activity for the clinical and educational aspects of venereal disease control.

Reporting by Private Physicians

Health officers were asked again this year to "summarize the results of any study made . . . of the reasons for under-reporting by private physicians."

Replies showed that very few studies were made in fiscal 1971. Seven states and 11 cities said that such a study was being considered.

The District of Columbia replied that: "1) Some physicians would report gonorrhea if complete epidemiologic services were provided by public health. 2) The physician's greatest concern is confidentiality and 'physician-patient' relationship. 3) Most physicians attempt to do their own epidemiology."

One health officer commented as follows: "I believe that many physicians are getting exasperated with the continued cry from health officials that under-reporting is the cause of the increase. We should sidestep this issue and try to offer positive means of control rather than sitting and blaming the private physicians."

Laboratories

An important procedure used to identify persons infected with syphilis and bring them to treatment when necessary is the reporting by laboratories to public health authorities by name of persons who have a reactive serologic test for syphilis. Wherever the procedure is used, the information is kept confidential and the person involved is contacted, if possible through his own physician, for follow-up diagnosis and treatment when necessary.

About seven times more early and late latent syphilis cases than infectious syphilis cases are reported each year by physicians in private practice. Most of these cases are picked up in the course of serologic testing.

In some states, even where no legal compulsion exists for laboratories to report, cooperation with the VD control program is evident.

Eight states of the 41 responding said that they had no law which required laboratories to report positive syphilis tests to the health department. Two of the eight states indicated that an effort to secure such legislation is under way. Of the eight states, four were unable to estimate the number of reactive tests which went unreported. Two states felt that at least 50% were not reported by laboratories, another state that it was less than 5%, and the fourth that none were unreported.

Recommendations for improving laboratory reporting of venereal disease have urged passage of laws or regulations that laboratories performing serologic tests be subject to inspection and approval by the health department in order to assure a high standard of technical performance. Table J, page 24, shows which states now have such laws or regulations.

Contact Investigation

Contact investigation involves, first, an interview with the patient in which he is asked about his sex contacts to determine the source and possible spread infections of his disease. Unless contacts are alerted to the possibility that they are infected, they may go undiagnosed and untreated for an indefinite period. And if they are sexually promiscuous, they may give a venereal disease to their other contacts and may even reinfect the patient himself.

The experience of interviewers has been that persons infected with a venereal disease seldom give information about all of their sex contacts in the initial interview, and consequently a reinterview is routinely scheduled. In the time between the first and second interviews, the infected person, now under treatment and relieved of anxiety about himself, has had time to consider the possible consequences to others with whom he has had sex contact. During the reinterview he may name additional contacts whom he did not remember, or whose names or addresses he did not recall at the time of the first interview.

In the search for persons who may have been exposed to infectious syphilis, as now conducted in most health departments in the United States, there is one more step. This is the interviewing of "cluster suspects" and "cluster associates," which leads to identification of additional cases of venereal disease. The patient, having now become interested and impressed with the concern shown by the interviewer about all persons who have been exposed to infection, names friends or acquaintances who may have been exposed to the same contacts, or who may, like himself, have lesions of syphilis. These are called "cluster suspects." Persons related epidemiologically to the patient but not named by him, who are discovered through the epidemiologic process to need an examination for syphilis, are designated "cluster associates."

When a sex contact to infectious syphilis or gonorrhea is clinically negative on first examination, treatment is given as a preventive measure to ensure that if he has an incubating disease, it will be aborted and the chain of infection broken.

An analysis of the degree to which contact investigation is applied to persons with primary and secondary syphilis is presented in Table K, page 26. Of total cases reported by 48 states, 95.8% were interviewed and 78.4% reinterviewed. This led to a high incidence group: of the contacts located and examined, 15.4% had previously undetected syphilis.

Giving preventive treatment routinely to named con-

TABLE K

CONTACT INVESTIGATION OF PRIMARY AND SECONDARY SYPHILIS

Fiscal Year 1971

(Data from 48 states and 126 counties and cities.)
(Part of county and city data included in state totals.)

Number of:	States	Cities
Patients Reported	19,649	15,710
Interviewed	18,820	14,800
Reinterviewed	15,410	12,195
Cluster Interviewed	10,468	7,731
Sex Contacts Located and Examined	39,996	27,613
Contacts Treated after Epidemiologic Investigation	6,169	4,783
Contacts Treated with No Evidence of Infection	16,760	14,783
Analysis:		
Percent Interviewed	95.8	94.2
Percent Reinterviewed	78.4	77.6
Percent Cluster Interviewed	53.3	49.2
Percent of Located and Examined Contacts Brought to Treatment for Syphilis	15.4	17.3
Percent of Examined Contacts Brought to Epidemiological Treatment	41.9	53.5
Number of Examined Contacts Per Infected Person Interviewed	2.1	1.9

Source: Joint Statement questionnaire

TABLE L

CONTACT INVESTIGATION OF GONORRHEA

Fiscal Year 1971

(Data from 15 states and 50 counties and cities.)
(Part of county and city data included in state totals.)

Number of:	States	Cities
Patients Reported	60,069	114,688
Interviewed	12,625	54,152
Sex Contacts Located and Examined	11,031	31,993
Contacts Treated after Epidemiologic Investigation	4,432	14,562
Contacts Treated with No Evidence of Infection	3,245	15,586
Analysis:		
Percent Interviewed	21.0	47.2
Percent of Examined Contacts Brought to Treatment for Gonorrhea	40.2	45.5
Percent of Examined Contacts Brought to Epidemiological Treatment	30.1	48.7
Number of Examined Contacts per Infected Person Interviewed	1.2	1.7

Source: Joint Statement questionnaire

TABLE M

PRIMARY AND SECONDARY SYPHILIS — ANALYSIS OF CONTACT INVESTIGATION BY STATES

Fiscal Year 1971

State	Number of Reported Cases	Percent of Reported Cases Interviewed	Percent Reinterviewed	Percent Cluster Interviewed	Number of P&S Contacts Located and Examined	Percent Brought to Treatment for Syphilis	Percent Brought to Epidemiologic Treatment
Alabama	163	100.0	100.0	100.0	802	9.2	63.2
Alaska	25	100.0	88.0	100.0	61	26.2	54.1
Arizona		N.R.	N.R.	N.R.	N.R.	N.R.	N.R.
Arkansas	326	99.4	92.0	52.5	946	14.4	49.2
California		INC.	INC.	INC.	INC.	INC.	INC.
Colorado	58	96.6	69.0	69.0	70	15.7	32.9
Connecticut	212	89.2	68.4	0.9	224	22.3	28.1
Delaware	64	100.0	92.2	95.3	90	32.2	38.9
Florida	1,630	98.0	93.1	49.0	3,359	11.8	53.4
Georgia	1,458	100.0	87.6	100.0	4,263	15.8	47.5
Hawaii	20	100.0	50.0	5.0	16	0.0	0.0
Idaho	6	83.3	83.3	83.3	7	14.3	57.1
Illinois	975	93.2	87.8	82.7	1,921	13.0	43.2
Indiana		INC.	INC.	INC.	INC.	INC.	INC.
Iowa	14	100.0	100.0	100.0	29	44.9	31.0
Kansas	67	95.5	95.5	95.5	130	16.2	34.6
Kentucky	298	99.7	96.3	95.0	676	15.0	38.3
Louisiana	747	100.0	93.7	100.0	1,784	16.5	35.2
Maine	10	100.0	70.0	100.0	22	13.6	40.9
Maryland	132	97.7	73.5	30.3	235	35.3	25.5
Massachusetts		INC.	INC.	INC.	INC.	INC.	INC.
Michigan	677	92.6	83.2	0.0	1,060	15.0	35.0
Minnesota	61	100.0	96.7	100.0	155	12.9	39.4
Mississippi	285	100.0	98.9	100.0	1,079	12.4	43.7
Missouri	265	98.9	94.3	98.5	618	13.4	40.9
Montana	2	100.0	100.0	0.0	0	—	—
Nebraska	23	100.0	91.3	100.0	54	9.3	35.2
Nevada	150	96.0	72.0	44.0	240	16.3	38.8
New Hampshire	6	100.0	100.0	0.0	10	10.0	10.0
New Jersey	1,049	97.7	91.8	97.7	1,917	18.6	43.5
New Mexico	143	95.1	62.2	95.1	265	14.3	26.0
New York	4,404	88.0	54.4	18.3	5,218	13.8	44.1
North Carolina	425	98.4	97.9	99.1	1,699	12.2	46.0
North Dakota	9	77.8	22.2	0.0	5	20.0	60.0
Ohio	440	99.0	94.8	99.1	1,061	13.3	43.1
Oklahoma	111	100.0	91.9	100.0	311	14.1	46.6
Oregon	26	96.2	84.6	76.9	38	13.2	28.9
Pennsylvania	378	97.6	94.2	85.7	657	20.1	47.9
Rhode Island	45	84.4	80.0	80.0	33	45.5	36.4
South Carolina	307	100.0	0.0	0.0	1,065	11.5	31.3
South Dakota	14	100.0	85.7	57.1	19	15.8	31.6
Tennessee	255	100.0	97.3	100.0	765	13.5	45.1
Texas	2,879	99.8	72.8	32.9	6,293	15.7	34.6
Utah	43	90.7	90.7	90.7	97	17.6	47.4
Vermont	3	66.6	66.6	66.6	5	0.0	20.0
Virginia	334	97.6	88.9	90.4	812	19.8	30.0
Washington	116	99.1	96.6	99.1	279	11.8	54.5
West Virginia	35	100.0	94.3	100.0	173	10.4	35.8
Wisconsin	67	95.5	88.1	88.1	N.R.	N.R.	N.R.
Wyoming	5	100.0	40.0	20.0	2	0.0	0.0
Puerto Rico	887	97.5	96.4	0.0	1,339	34.7	30.3
Total	19,299	95.8	78.4	53.3	39,996	15.4	41.9

N.R. — No Response
INC. — Incomplete Response

Source: Joint Statement questionnaire

TABLE N

GONORRHEA — ANALYSIS OF CONTACT INVESTIGATION BY STATES

Fiscal Year 1971

State	Number of Reported Cases	Percent of Reported Cases Interviewed	Number of Contacts Located and Examined	Percent of Located and Examined Contacts	
				Brought to Treatment for Gonorrhea	Brought to Epidemiological Treatment
Alaska	2,527	58.0	733	33.4	16.2
Hawaii	1,432	19.8	135	42.2	26.6
Idaho	1,486	63.1	861	28.7	42.9
Indiana	8,035	9.2	438	65.3	41.6
Maine	1,259	16.4	83	25.3	56.6
New Hampshire	533	56.5	440	23.6	48.4
New Jersey	10,202	22.1	2,143	30.3	33.9
North Dakota	587	24.7	142	60.6	33.8
South Carolina	12,901	0.9	89	31.5	33.7
Utah	1,002	68.0	785	51.2	37.7
Vermont	457	33.9	244	29.1	7.8
Virginia	15,391	29.8	4,241	46.7	24.9
West Virginia	1,835	11.1	252	28.2	0.0
Wyoming	215	24.7	20	30.0	30.0
Puerto Rico	2,207	23.0	425	41.4	54.6
Total	60,069	21.0	11,031	40.2	30.1

Source: Joint Statement Questionnaire

tacts who have no evidence of disease has gained acceptance in the United States. Among located contacts to primary and secondary syphilis in 48 states, 41.9% received preventive (or epidemiologic) treatment, according to replies to this year's questionnaire.

An analysis of case investigations of reported primary and secondary syphilis cases made by state health departments in FY 1971 is shown in Table M, page 27. Despite low percentages in some areas, the percentage of reported primary and secondary syphilis cases interviewed by states was 95.8%.

Data on case investigation of gonorrhea were submitted by 15 states and are presented in Table N, this page. These states interviewed only a fraction of total reported cases. Public health authorities have in the past not emphasized interviewing gonorrhea patients because they felt that: 1) The short incubation period would make it almost impossible to reach exposed persons before gonorrhea developed. 2) Because of their symptoms, infected males would seek treatment promptly. 3) There would be little impact on gonorrhea incidence due to the sheer size of the problem. 4) It would be too expensive. This defeatist attitude is fortunately changing. Techniques of contact investigation appropriate to large-scale gonorrhea control programs are being evaluated in a number of areas.

Data on results of case investigations of gonorrhea in Table L, page 26, show that only 21.0% of gonorrhea patients were interviewed in the 15 states responding and 47.2% were interviewed in the 50 counties and cities responding. (Many health departments indicated that males only were interviewed. Priority is often given to interviewing male patients because the duration of their infection is known more often, while that of females is more likely to be in doubt.)

A very high percentage of examined contacts had previously undetected gonorrhea: 40.2% in states and 45.5% in counties and cities. This evidence strengthens the argument that contact investigation should become an integral part of gonorrhea control.

Interstate and International Exchange of Venereal Disease Contact Information

Because the population of the United States is extremely mobile, a high rate of interstate and international transmission of the venereal diseases occurs. In the case of infectious syphilis, a continuing exchange of information about sources of infection and contacts takes place among city, county and state health departments and with the health officers of foreign countries. Interstate and international exchange of gonorrhea contact information is far less extensive than that for syphilis.

The epidemiological procedures used by health departments having venereal disease services begin with an interview of the

TABLE O

INTERSTATE AND INTERNATIONAL EXCHANGE OF CONTACT INFORMATION FOR PRIMARY, SECONDARY, AND EARLY LATENT (UNDER ONE YEAR DURATION) SYPHILIS

Fiscal Year 1971

Area	Number of Areas from which Forms Were Received	Number of Contact Forms Received	Percent of Contacts Located	Percent of Located Contacts Brought to Treatment for Syphilis
Alabama	27	180	71.7	10.1
Alaska	4	7	57.1	25.0
Arizona	17	65	41.5	11.1
Arkansas	23	122	69.7	15.3
California	42	784	61.0	9.2
Los Angeles	36	473	57.5	10.7
San Francisco	30	312	61.2	3.1
Colorado	25	86	36.0	9.7
Connecticut	20	81	53.1	4.7
Delaware	15	38	68.4	7.7
District of Columbia	26	312	54.2	12.4
Florida	35	563	52.9	8.7
Georgia	31	436	59.4	13.5
Hawaii	8	35	31.4	9.1
Idaho	9	13	38.5	20.0
Illinois	33	143	60.1	10.5
Chicago	36	351	53.8	7.9
Indiana	28	175	25.7	11.1
Iowa	13	30	63.3	0.0
Kansas	27	86	61.6	5.7
Kentucky	23	123	65.9	3.7
Louisiana	29	347	61.4	14.6
Maine	5	5	40.0	0.0
Maryland	15	194	55.2	10.3
Baltimore	23	96	45.8	2.3
Massachusetts	29	144	46.5	16.4
Michigan	30	224	46.0	13.6
Minnesota	16	40	47.5	5.3
Mississippi	25	154	74.0	8.8
Missouri	25	130	67.7	12.5
Montana	10	14	57.1	0.0
Navajo	7	42	57.1	12.5
Nebraska	12	22	68.2	6.7
Nevada	18	59	64.4	10.5
New Hampshire	4	4	50.0	0.0
New Jersey	33	383	46.0	15.3
New Mexico	12	32	62.5	10.0
New York	32	338	45.6	12.3
New York City	41	982	43.4	10.6
North Carolina	28	275	60.7	9.6
North Dakota	4	4	50.0	0.0
Ohio	30	254	67.3	7.6
Oklahoma	27	101	68.3	13.0
Oregon	18	47	44.7	4.8
Pennsylvania	27	146	45.2	10.6
Philadelphia	25	142	53.5	7.9
Rhode Island	10	26	65.4	5.9
South Carolina	23	212	62.7	13.5
South Dakota	8	12	75.0	11.1
Tennessee	24	139	66.2	7.6
Texas	43	549	59.0	13.3
Utah	11	26	92.3	4.2
Vermont	4	9	77.8	28.6
Virginia	29	215	60.5	10.0
Washington	26	89	67.4	11.7
West Virginia	14	43	72.1	6.5
Wisconsin	17	67	50.7	8.8
Wyoming	4	5	40.0	50.0
Puerto Rico	14	107	30.8	12.1
Virgin Islands	7	25	8.0	0.0
United States and Territories	—	10,118	55.3	10.4
Canada	15	59	30.5	5.6
Mexico	21	381	28.9	32.7
Vietnam	29	81	25.9	23.8
Other Foreign	41	451	11.1	12.0
Unknown	17	40	22.5	33.3
Grand Total	—	11,130	52.1	10.9

Source: Public Health Service

infected person by a trained contact investigator. Information is elicited concerning the probable source of the infection and probable sex contacts who also might be infected.. An *Epidemiologic Report Form* is prepared on each contact named. Contacts are encouraged to seek medical examination, either from private physicians or public clinics. When contacts are located in another city, state or country, the form is sent to the health officer in that area.

Table O shows the number of areas from which contact forms were received by each state, as well as the percentage of contacts located from the forms and the percentage of contacts diagnosed as infected with infectious syphilis for each state.

A total of 11,130 primary and secondary and early latent syphilis contact report forms were involved in the interstate and international transmission of infectious syphilis contact information. Persons were located from 52.1% of these forms. Of those located, 10.9% were brought to treatment for a previously unknown case of syphilis. Such cases might not have been found without the interstate exchange of information. Control of syphilis involves coordinated efforts not only within the community, but between states and nations as well. For example, according to Table O, 30 states received and acted upon contact information sent from 25 or more areas. No state stands alone in the control of venereal disease. Every state, the District of Columbia, Puerto Rico and the Territory of the Virgin Islands exchanged contact forms on potential source or spread infections with some other area.

In addition to the large number of contact forms involved on an interstate basis, states exchange information on persons involved in interstate travel who have laboratory tests that are reactive on STS. A total of 31 states and Puerto Rico reported that they had received and investigated 3,366 reactors sent from other states and that 9.0% of these were brought to treatment for a previously unknown syphilis infection. The volume of interstate exchange of forms on reactors (STS) recorded here would be much larger if information could have been obtained from the 19 states that did not provide the Joint Statement with such information.

Screening for Gonorrhea

It is doubtful that contact tracing alone will identify enough women with asymptomatic gonorrhea to have a clear impact on the level of disease, despite the high yield from this activity shown in Table L.

Screening programs which include a culture for gonorrhea on women already receiving a pelvic examination for various reasons have had encouraging results. In studies supported by the Public Health Service, high rates of gonorrhea were found in the patient population served by several types of health care providers in a wide range of cities. The results of these screening programs by types of health care providers are shown in Figure 9, page 60.

While positive cultures were found most often in public supported, organized health care settings, the rates of infection in almost any group studied were significantly high.

Efforts should be made immediately to institute culture screening programs in all health care settings which provide pelvic examinations to young, sexually active females. Although the extent of such screening was not specifically asked in this year's questionnaire, many health departments stated that limited programs were being established. Considerable expansion of existing laboratory services and increased personnel are needed so that health departments can "follow-up" on women found to have positive cultures for gonorrhea.

Treatment of Minors

The number of states with laws permitting minors to give their own consent for venereal disease treatment has increased from 14 in 1968 to 41 in 1971, and includes the District of Columbia and the Virgin Islands.

As of October 1971, the following states and Puerto Rico had no law specifically permitting physicians to give medical treatment to minors without parental consent:

Arizona	Vermont*
Idaho*	Virginia*
Mississippi	Wisconsin
New Hampshire*	Wyoming
South Carolina*	

*States with an Attorney General's opinion permitting treatment of minors without parental consent.

There is considerable variation in wording of the laws. Some states specify the youngest age limit of the minor, such as: "a minor 12 years or older," or *"a minor 18 years or older."* Texas law, on the other hand, provides that, "Any person, regardless of age, has the capacity to consent to examination and treatment by a licensed physician for any venereal disease."

In Hawaii, the law allows minors 14 or over to consent to venereal disease treatment, but physicians must inform "spouse, parent, custodian or guardian" of any minor patient under 18 found actually to have VD.

Restrictions in the law serve to defeat the purpose of the law: to aid in rapid diagnosis and treatment of minors at a time when the venereal disease rates are rising within that age group.

VENEREAL DISEASE EDUCATION

Venereal Disease Education in Schools

Replies to the Joint Statement questionnaire show that in FY 1971, 73% of the 5,013 junior and senior high schools in 109 counties and cities included venereal disease information in the curriculum.

Teachers require special training to teach about the venereal diseases. Colleges and universities with teacher training programs include venereal disease education in the curriculum in 29 of the 50 states responding and in Puerto Rico, and in 57 out of 145 counties and cities.

Some states have legal restrictions imposed upon VD instruction. However, 40 states responded that there was state approval of the inclusion of venereal disease information in the school curriculum. Massachusetts said that it was a "local decision." In California, the state department of education developed a "Framework for Health Instruction, Kindergarten through Grade 12." VD instruction was recommended for classes covering diseases, especially communicable diseases.

The following nine states replied that there was no approval of the inclusion of VD information in the school curriculum: Alabama, Connecticut, Louisiana, Mississippi, Nebraska, Nevada, Rhode Island, Tennessee and Virginia. Of the 147 counties and cities responding, 79% said that there was local approval of such instruction. The response is somewhat below the approval indicated two years ago by the questionnaires and is the same percentage as last year. There has apparently been very little recent progress in gaining such approval.

Cooperation between health departments and community groups to secure or strengthen inclusion of VD information in the curriculum did, however, improve between FY 1970 and FY 1971. According to replies from 50 states and 150 cities and counties, over 80% of their departments of education, other educational programs, operations or agencies, and citizen groups or committees worked with health departments to secure or strengthen inclusion. Improved cooperation was reported, especially between health departments and citizen groups or committees.

Table P shows when and where VD information was

TABLE P

VENEREAL DISEASE EDUCATION IN JUNIOR AND SENIOR HIGH SCHOOLS

Replies from 109 Counties and Cities

Grades that included VD education	Number of times included	Percent of total times included	Courses that included VD education	Number of times included	Percent of total times included
6th	40	3.8	Biology	166	15.7
7th	92	8.7	Family Life Education	207	19.6
8th	128	12.1	Health Education	291	27.5
9th	187	17.7	Physical Education	256	24.2
10th	217	20.5	Science	138	13.0
11th	199	18.8	Total	1,058	100.0
12th	195	18.4			
Total	1,058	100.0			

Source: Joint Statement questionnaire

(Other courses mentioned, but not tabulated because of insufficient data, include the following: driver's education; English; general assemblies; government; homemaking; human growth and development; life science; physiology; psychology; religion; senior problems; social science and sociology.)

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presented during the high school years in 109 counties and cities during FY 1971.

Venereal disease instruction was given most often in health education and physical education courses, usually in grades 9-12. Some form of VD education or information was presented an average of 9.7 times during the high school years in these counties and cities, which listed a total of 1,058 instances by grade and course. Parental demand, as well as cooperation between departments of health and departments of education, was crucial in achieving the amount of VD teaching reflected here.

The need for instruction in the sixth grade has often been emphasized by authorities on the venereal diseases. Only 3.8% (40 out of 1,058) of the grades and courses listed by the counties and cities as including VD information were on the sixth grade level. According to the Public Health Service, the 10-14 age group (which would have a high percentage of sixth graders in it) had a 19.7% increase in gonorrhea from calendar 1969 to 1970, with 5,289 cases reported in 1970.

The proceedings of the 1971 International Venereal Disease Symposium (See next column.) summarize the recommendations made by its workshop on education, stating that "venereal disease information should be in the communicable disease curriculum . . . high school or junior high school courses should stress that venereal diseases do exist, that they are epidemic, that some students may be affected by them, and that we can and should do something about them. If any student has the slightest suspicion or is for any reason worried that he may have a venereal disease, he should be advised to get a medical examination. Contacts must be brought in, in order to eliminate the disease from the community."

"The subject of VD should be taught in regular classrooms by classroom teachers, who could be specially trained—perhaps by public health organizations—through credit courses."

Effect of VD Education on VD Incidence

This year's questionnaire asked whether any method of evaluating the effect of VD education on the teenage VD rate had been established. A majority of replies said that increased self-referrals for treatment by the young were the best evidence of the effect of VD education. The Monterey County, California, health department stated that, "There is no evidence that VD education has lowered our county VD rate, but it has greatly facilitated earlier diagnosis through self-referral and speeded up contact follow-up and immeasurably increased community awareness and interest in finding out the extent of the problem."

Self-referral patients in one city were asked routinely why they had come to the clinic. Records kept of their replies showed that over 35% mentioned school VD education programs or radio and TV announcements.

Increased knowledge shown by young patients about gonorrhea and about its lack of symptoms in females was often cited as evidence that VD education had been effective.

VD Information in the Community

A publication of significance which received wide distribution was *The VD Crisis*, from the proceedings of the International Venereal Disease Symposium, St. Louis, Missouri, 1971, co-sponsored by ASHA and Pfizer Laboratories Division, Pfizer, Inc.

The Southern Medical Association devoted the entire April 1971 issue of its *Bulletin* to the subject of gonorrhea.

Among publications with special issues on venereal disease were: *American Pharmaceutical Association Journal* (August 1971); *Maternal and Child Health* (November 1971) and *Ohio's Health* (September-October 1971).

The Joint Statement questionnaire asked health officers to describe the most effective VD education and public information programs carried on in their jurisdiction in FY 1971. The following replies reflect the wide variety of community groups and activities involved in promoting awareness of the venereal diseases.

> "There were three statewide associations accepting VD as a main health project during the year: California Federation of Women's Clubs, Junior Membership; the California Pharmaceutical Association and the California Jaycees.
>
> "Some California Pharmaceutical Association activities were: 1. Three VD 'Teach-Ins.' 2. A VD counter display placed in all pharmacies in the state. 3. Press conferences. 4. Promotion of legislation that enables pharmacies to display prophylactics when accompanied by VD literature. 5. Development of a VD message for prescription bags.
>
> "The California Jaycees plan first to educate their membership and then involve the local Jaycees with the youth VD education program.
>
> "The 'Juniors' were very much involved with projects during the year. A VD song was written and recorded into VD radio spots. One high school planned and built an exhibit and then donated it along with 100 different poster ideas to their county health department.
>
> "Organizations similar to the Bay Area Venereal Disease Association appeared in Ventura, Fresno,

Sacramento and Bakersfield. BAVDA was extremely active during the year. Its main thrusts were sponsorship of a seminar for physicians; the April VD Awareness Month; a new TV spot, along with numerous TV and radio programs; and a rock concert.

"The Alameda-Contra Costa Medical Auxiliary sponsored a VD seminar that was well attended by local educators.

"In January 1971, the state board of public health created the California Task Force on Venereal Disease, composed of 27 professionals and private citizens within the state charged with the responsibility to review the extent and nature of the VD problem in California and make recommendations. The task force reported its findings and recommendations to the state board of public health. The recommendations were acted upon favorably by the board and the state legislature. As a result, $238,000 was set aside to carry out the recommendations."

"During the Spring of 1971, a group of University of Denver graduate students undertook an intensive VD awareness campaign in the Denver metropolitan area. The 'VD, Silent Epidemic' drive, sponsored by our agency, consisted of an eight-week effort which utilized all forms of media, various professional and citizen groups.

"Purpose of the campaign was to inform the general public of the growing problem and to refer individuals 15-25 years old to clinics and physicians for VD examinations. Referrals were encouraged to a specific phone number set up to give general and clinic information.

"During the campaign, 2,733 phone calls were received by the 'hot line' and 1,632 new patients were seen in area clinics, with 409 cases of VD treated by these clinics."

"February, 1971, was 'VD Awareness Month' in Connecticut. Mass media campaign sponsored by state department of health, ASHA, Connecticut Pharmaceutical Inc., Pfizer Co., and Connecticut Junior Women's Clubs. Theme of campaign was 'VD: It's a Bummer.' Utilized radio spots, billboards, pamphlets, television programs, in addition to mailing information packets to 2,300 schools, colleges, libraries and youth serving agencies. Campaign was endorsed by Connecticut State Board of Education, Connecticut State Medical Society, Connecticut Broadcasters Association, Connecticut Business and Industry Council and Connecticut Public Health Association."

"The most significant public awareness program was set up by the New York Alliance for the Eradication of VD entitled 'Partners in VD Prevention.' Led by the alliance and with the cooperation of the New York City Department of Health, the services of some 200 Neighborhood Youth Corps personnel and other community people were utilized for a door-to-door VD information campaign. The program successfully accomplished its two main objectives – as well as reaching 25,000 people with VD information: a) public recognition of the concept of VD prevention and the use of prophylactics as an acceptable solution to the VD problem; b) publicity on the VD problem. Some 400 newspapers covered such events as the corner distribution of 'Fight Love Pollution' matchbooks and New York City's 'VD Light-In'– a flashlight parade of about 100 teenagers down Fifth Avenue. The program also created and introduced a VD newsletter entitled *Rx for VD*, designed for professionals in the medical and pharmaceutical fields."

"The Second Conference on Venereal Disease Among Teenagers was held in Philadelphia October 7, 1970. It received the most widespread community support and mass media coverage of any effort to date. Two major results of the conference were the establishment of Operation Venus and the Counterattack Committee.

"Operation Venus is the most effective program for public awareness and information in Philadelphia. The program was established by the Community Service Corps (an organization of high school students.) The two basic elements of Operation Venus are a 'hot line' and a transportation service to private physicians and public clinics. The program has received wide publicity."

"Governor Frank Licht (of Rhode Island) today announced a statewide effort to reduce venereal disease, which has reached panic proportions in the state, and 'is probably doing far more physical and mental damage to our citizens than the drug problem.'

"A three-month program, beginning immediately, will emphasize the state's ongoing program of free and confidential medical assistance to persons affected by a venereal disease. People suspecting that they have the disease only need telephone 421-9836 to arrange an examination and treatment.

"The theme of the program, *Let's Get V.D.*, will be particularly directed to the 14-25 age group, where incidence of venereal disease is the greatest. A key to the campaign is that young adults can be treated

without parental approval, and in strict confidence.

"The program will be executed with the cooperation of all the news media, the neighborhood health centers, hospitals, private physicians, public assistance employees, schools, and many other organizations and groups.

"'We intend to blanket the state with our messages to be sure that we sufficiently impress on the minds of all people the seriousness of this disease,' Governor Licht said." (from a December 16, 1970 press release)

"Approximately 35,000 males visit barber shops in Houston each day. For this reason, the Texas Alliance for the Eradication of VD asked 832 barbers in Houston to set up VD information centers in their shops. Each received a specially designed poster appropriate for display, along with a supply of bumper stickers and pamphlets that they were asked to distribute. The Texas Alliance also sponsored a billboard campaign. The Harris County Medical Society launched a 'Stamp Out VD' campaign which encouraged doctors to report all cases to the health department and which also promoted classroom VD education."

"The VD control program distributed over 3,000 VD information resource kits to school teachers and others who are involved in teaching about the venereal diseases. Nearly 500,000 pieces of literature were provided to schools and other organizations for distribution to students, employees, etc. Ten VD films were shown 4,178 times to audiences which included students, physicians, paramedical groups—an estimated 156,000 persons." (Texas)

"We undertook a program to educate male homosexuals in the southeastern Wisconsin area. Main thrust of program was the distribution of posters and leaflets describing venereal disease among male homosexuals. Volunteer rate of male homosexuals at Milwaukee Social Hygiene Clinic increased markedly as a result of this effort."

Public Awareness

Table Q, below, summarizes views of state and city health officers on the level of public awareness of the venereal disease problem in FY 1971. The press, magazines, technical journals, radio and television gave a great amount of attention to the subject during the year, with increased newspaper, radio and TV coverage noted by 44 state health departments and 120 city health departments. Self-referrals to clinics also showed a large increase during the year. A comparison with last year's table shows that there was marked improvement of public awareness in all the areas listed on the table. A great deal of credit for this change must go to the many health departments and community groups whose vigorous and imaginative efforts to inform the public are documented in replies to the questionnaire. A selection of these replies was quoted in the previous section.

TABLE Q

PUBLIC AWARENESS OF VD

Fiscal Year 1971

	50 states and Puerto Rico			152 counties and cities		
	Increased	Decreased	Stable	Increased	Decreased	Stable
Better reporting by private physicians	27	4	20	73	8	71
Self-referrals to clinics	40	0	11	136	1	14
Newspaper, radio and TV coverage	44	0	7	120	2	30
Requests for VD information (speakers, films, materials) by community groups	38	1	12	113	2	37
Requests for educational material by public schools and colleges	36	2	13	92	3	49
Request for talks and information by physicians' professional societies	14	2	35	41	12	92
Requests for health department services by private physicians	30	2	19	83	2	68
Total	229	11	117	658	30	361

Source: Joint Statement questionnaire

TABLE R

TEACHING ASSOCIATION BETWEEN HEALTH DEPARTMENTS AND PROFESSIONAL SCHOOLS

Total schools of medicine and osteopathy with which health departments have association

Type of VD Instruction	Replies from 50 states and Puerto Rico		Replies from 148 counties and cities	
	Number of Schools	Percent of Total Schools	Number of Schools	Percent of Total Schools
Teaching	37	45.1	31	41.3
Providing clinical material	46	56.1	41	54.7
Providing a clinic site	24	29.3	18	24.0
Apprenticeship program	9	11.0	21	28.0
Seminars	29	35.4	26	34.7
Research problems	16	19.5	16	21.3
Occasional lecturing	55	67.1	53	70.7

(Number of schools in states responding: 82; in cities: 75.)

Total schools of nursing with which health departments have association

Type of VD Instruction	Replies from 50 states and Puerto Rico		Replies from 148 counties and cities	
	Number of Schools	Percent of Total Schools	Number of Schools	Percent of Total Schools
Teaching	217	20.7	167	28.0
Providing clinical material	136	13.0	141	23.7
Providing a clinic site	71	6.8	84	14.1
Apprenticeship program	45	4.3	37	6.2
Seminars	133	12.8	110	18.5
Research problems	50	4.8	28	4.7
Occasional lecturing	296	28.2	292	49.0

(Number of schools in states responding: 1,049; in cities: 596.)

Source: Joint Statement questionnaire

Teaching Association Between Health Departments and Professional Schools

Table R, above, documents the very unsatisfactory status of health department participation in VD education in professional schools of medicine and nursing. Obviously, such schools may and do provide some VD teaching without the participation of health departments. Nevertheless, the fact that health departments participate in VD teaching in no more than about one half of the medical schools and only one fourth of the schools of nursing indicates the weakness of VD education in professional schools.

FEDERAL FUNDING

The project grant mechanism has been used by the federal government to assist state and local health departments in the control of the venereal diseases since 1953. Prior to the implementation of the Partnership for Health legislation in July 1967, project grant support was provided from categorical funds appropriated specifically for venereal disease control.

The Partnership for Health legislation provided, in Section 314a of the Public Health Service Act, for grants to assist the states in developing comprehensive plans for all health needs, under a designated Comprehensive Health Planning agency. Section 314b of the same act provided grant assistance for the development of area-wide plans in approved regional or metropolitan local areas. Section 314c provided grant funds which are now administered by the National Center for Health Services Research and Development, for the development of new methods or improving existing methods of organizing, delivering and financing health services.

Section 314d of the Public Health Service Act established a mechanism for block ("formula") grants to states for the delivery of health services. Each state has an entitlement under Section 314d which is based on population. States submit a program plan for each health activity for which they propose to use 314d funds, and must pay a proportionate share of the cost of the plan based upon per capita income. The 314d grants replace many previous categorical formula and project grants. States now, as in the past, do not use significant amounts of the "formula" grants for venereal disease control.

Prior to FY 1963, venereal disease project grant funds amounted to less than $3,000,000 each year. After the report of the Surgeon General's 1962 Task Force on the Eradication of Syphilis, project grant funds for venereal disease increased to a high in FY 1965, FY 1966, and FY 1967 of $6,229,000 per year. As recommended by the task force, these funds were limited to syphilis control programs.

Beginning with FY 1968, both ongoing and new venereal disease control projects have been awarded to state and local health departments from funds appropriated under Section 314e of the PHS Act. These grants have continued to be limited almost entirely to syphilis control programs. This section replaced several sources of authority for a variety of categorical project grants, including venereal disease. Although venereal disease project grant requests have had to compete with a wide variety of grant requests for many kinds of health services, project grant support continued through FY 1970 at a level approximately equivalent to that of the years before the Partnership for Health legislation was enacted. However, inflation (particularly increasing personnel costs) has decreased program activities.

FY 1971 and FY 1972 have seen a change in the pattern of federal grants to state and local health departments for venereal disease control under Section 314e. A

total of $6,300,000 was "set aside" for syphilis grants in each year. Eligibility for grants was established with respect to the extent of the early syphilis problem. Since many states did not meet the criteria for support at a level equivalent to prior years, grant support was drastically curtailed in some areas and eliminated in others. Areas with increased problems received increased grant support. Some states in which special efforts had achieved a reduction in reported infectious syphilis had federal project grants cut almost immediately.

The federal government actually provided $8,245,840 to states and cities for venereal disease control activities during FY 1971, and $24,357,000 has been spent, or is currently programmed to be spent, during FY 1972. According to the Public Health Service, these funds break down as follows:

	FY 1971	FY 1972
314e project grants	$6,300,000	$6,300,000
317 project grants	—	$16,000,000
CDC supported personnel provided directly to states and cities	$1,311,200	$1,657,000
CDC supported Gonorrhea Control Pilot Studies (FY 72 estimated)	$634,640	$400,000
Total	$8,245,840	$24,357,000

The program envisioned by the planners of Partnership for Health legislation is not yet fully operational in all states. Since all project grants for VD control are now funded through the appropriation for Comprehensive Health Planning (even though they are continuations of grants formerly awarded by the VD Branch of CDC), the only source of information from which total funds expended for VD control can be ascertained is state and city health departments. Replies to the Joint Statement from 45 states, the District of Columbia and Puerto Rico show that state funds made available to health departments for VD control increased by 21.7% from FY 1971 to FY 1972. Increased state funding was reported by 30 of the states responding, with four states (Georgia, Pennsylvania, Tennessee and Texas) and the District of Columbia accounting for over half of the increase. The 15 largest U.S. cities reported that local funds appropriated for VD control increased by 10.3% from FY 1971 to FY 1972.

Public Law 91-464, "The Communicable Disease Control Amendments of 1970," was enacted in October 1970. It provided appropriation authority for FY 1971 and FY 1972, to make grants to state and local health authorities for the control of tuberculosis, venereal disease, rubella, measles, RH disease, poliomyelitis, diphtheria, tetanus, whooping cough or other communicable diseases, amenable to reduction and determined by the Secretary of HEW on the recommendation of the National Advisory Health Council to be of national significance.

A small appropriation was made under this legislation for FY 1971, all of which was used to fund tuberculosis control activities. The appropriation in August 1971 of $20,000,000 – $16,000,000 of it for venereal disease control – was made under this authority and represents a renewed commitment by Congress to eradicate syphilis and its first real commitment to the control of gonorrhea. The status of these funds is discussed in the Progress Report.

In an attempt to discover the effect that changes in federal funding have upon state control programs, health officers were asked to comment upon such changes in FY 1971 and to anticipate the situation in FY 1972. Most states said their control programs had been curtailed. The following selection of comments from health officers documents the problem.

> "Arizona had requested $30,096 federal financial assistance in FY 1971. The amount approved was none. An emergency special state appropriation was granted by the state legislature to support in FY 1971 the personnel and related costs of the two Navajo Indian investigators and one clerk, as well as the in and out of state travel costs previously supported by federal funds. Federal financial support in FY 1972 totals $1,875 for communications equipment, out of state travel and educational materials."

> "Federal budget restrictions have created a cutback in personnel and California is experiencing a rapid increase in infectious syphilis cases. Cost of living increases will cause a further cutback in FY 1972 in that budget levels were not increased."

> "VD control is no longer a categorical program in Georgia. It has become a part of the department's Comprehensive Health delivery plan and all former categorical health program representatives have become generalists assigned to the district directors of public health.

> "Our program has suffered during FY 1971 from reduced federal funding, but our federal budget grants for FY 1972 for Fulton County have been increased and should result in a considerably improved program in the Atlanta area."

> "Since FY 1968 we have lost five Public Health

Service assignee positions. The cutback in CDC operating money for assignees has placed the higher paid PHS assignees on grant monies which results in less money for other services. Travel monies are severely limited. None of the 314d funds could be used for venereal disease control in Louisiana."

"We have applied for 314d funding but have not received funds from this source. Our project grant funds (314e) have been cut by almost 75% over the past five years. Personnel staffing is less than half the level of five years ago. Unfortunately the venereal disease problem remains serious and we cannot afford this reduction in assistance without losing some degree of program effectiveness." (Missouri)

"New York State did not receive the number of public health advisors we considered necessary to carry out our venereal disease control program. As a result, we are now showing increases in our syphilis incidence and gonorrhea is reaching epidemic proportions."

"FY 1971: Reduced cash and personnel, coupled with almost twice the primary and secondary syphilis morbidity of previous years, forced reduction of most program activities other than early syphilis epidemiology. FY 1972: More of the same." (Washington)

A WORLDWIDE VIEW

Note: *The following section was presented by Richard R. Willcox, M.D., at the International Venereal Disease Symposium held in St. Louis, Missouri, in 1971 under the co-sponsorship of ASHA and Pfizer Laboratories Division, Pfizer, Inc. It was published by Pfizer in* The VD Crisis, *an abbreviated version of the proceedings of that symposium. Dr. Willcox is consultant venereologist at St. Mary's Hospital in London and King Edward VII Hospital in Windsor, England. He is also a member of the WHO Expert Panel on Venereal Infections and Treponematoses.*

Many of the problems of venereal disease are not those of the United States alone, but are shared by all mankind. During the past decade most countries have witnessed a noticeable increase in the venereal diseases, following a sharp decline after World War II. Although the reported incidence of primary and secondary syphilis has risen markedly in some countries (Figs. 1 and 2), in others it has followed yearly variations.

Further, there has been a decline in the number of cases of late symptomatic syphilis in countries where such statistics are available, and of early congenital syphilis in nearly all countries. But these welcome events provide almost the only brightness in an otherwise somber scene.

Current trends in gonorrhea in various countries are illustrated in Figure 3. It must be borne in mind that differences in reporting make precise comparisons impossible. Nevertheless, according to the World Health Organization, the current rate in Sweden is 485 per 100,000, while in the United States it is as high as 900 per 100,000. The majority of these cases elude contact tracing.

Moreover, there are many other sexually transmitted diseases caused by spirochetes, bacteria, viruses, protozoa, fungi, and parasites, the numbers of which are not even recorded in most countries (Fig. 4). Other sexually transmitted organisms wait in the wings, as it were, seeking a role.

In England and Wales, the number of men with nonspecific urethritis now well exceeds those with gonorrhea. Indeed, patients with syphilis and gonorrhea comprise only about one-quarter of males and one-fifth of females attending venereal disease clinics.

Figure 5 shows the astronomical rise in the number of gonorrhea cases that has taken place in England and Wales. A number of factors account for this rise; however, data from these and other countries indicate clearly that population growth is responsible for only a small part.

Among other environmental and sociologic factors, the most important is the vast increase in holiday and business travel, which multiplies the opportunities for sexual encounter and also introduces venereal disease into previously inviolate areas. Particularly high venereal disease rates have always been noted among the mobile sections of the working community.

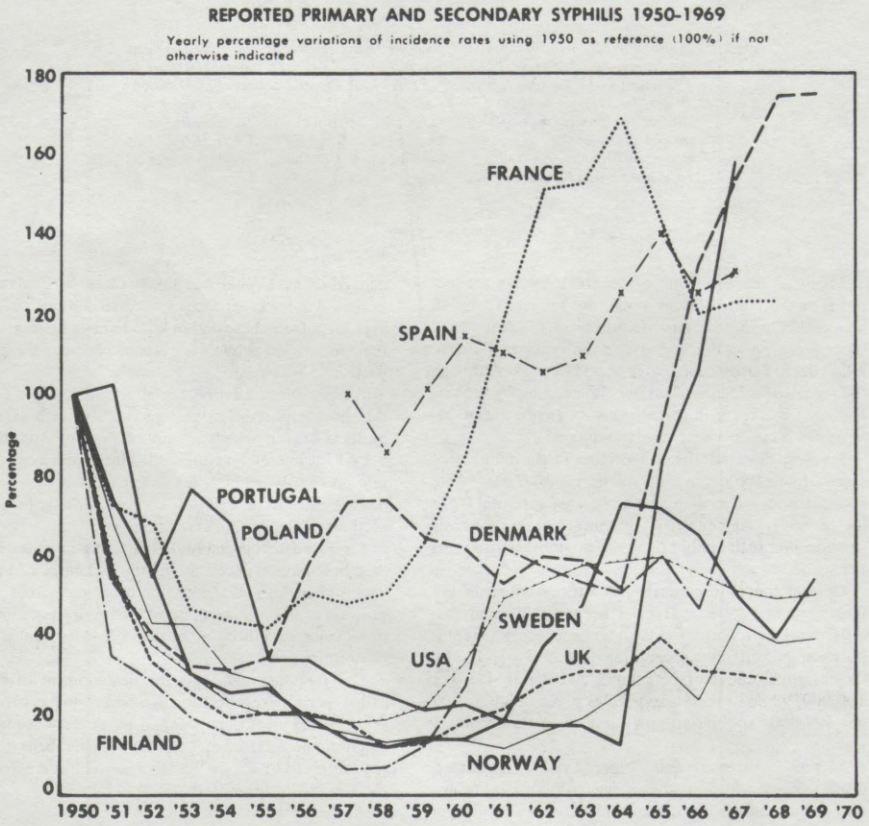
Improved social conditions resulting in a more hygienic host have reduced the number of cases of sexually acquired syphilis and have eliminated chancroid from a position of importance in developed countries. However, these gains have been more than offset by changing behavioral patterns.

The postwar years saw the development of the so-called permissive society, in which "doing your own thing" often meant one thing in particular—namely, indiscriminate heterosexual and homosexual behavior. Attention given to sex by the mass media has created a vicious circle in this respect.

At the same time, the traditional restraining influences of religion, family, and public opinion have been on the wane. The rates of divorce, broken homes, and illegitimacy continue to mount. Fear of venereal disease has diminished with the knowledge that simple, effective treatments are available, and apathy resulting from this knowledge has led to the problem of the chronic repeater.

Technologic progress has produced improved contraceptives, in the pill and the intrauterine device. But unlike the condom, these offer no protection against vene-

FIGURE 1


REPORTED PRIMARY AND SECONDARY SYPHILIS 1950-1969
Yearly percentage variations of incidence rates using 1950 as reference (100%) if not otherwise indicated
Percentage
180
160
140
120
100
80
60
40
20
0
1950 '51 '52 '53 '54 '55 '56 '57 '58 '59 '60 '61 '62 '63 '64 '65 '66 '67 '68 '69 '70
FRANCE
SPAIN
PORTUGAL
POLAND
DENMARK
SWEDEN
USA
UK
FINLAND
NORWAY

REPORTED PRIMARY/SECONDARY SYPHILIS 1960-1969.

Yearly percentage variations in incidence rates using 1960 as reference (100%)

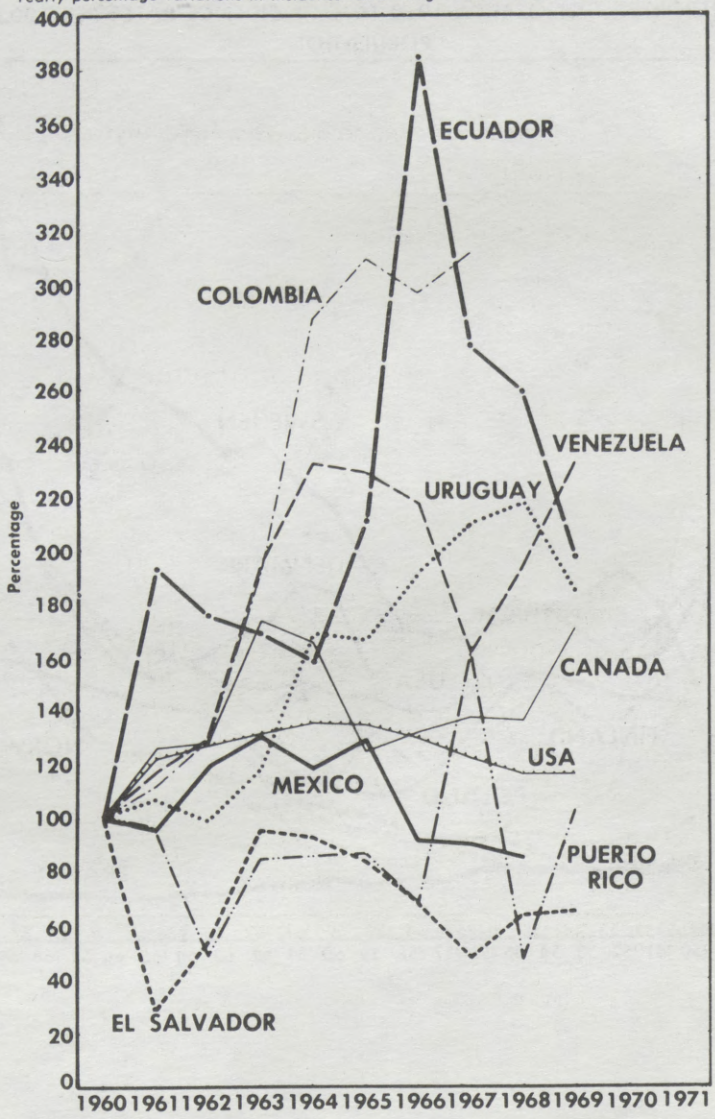
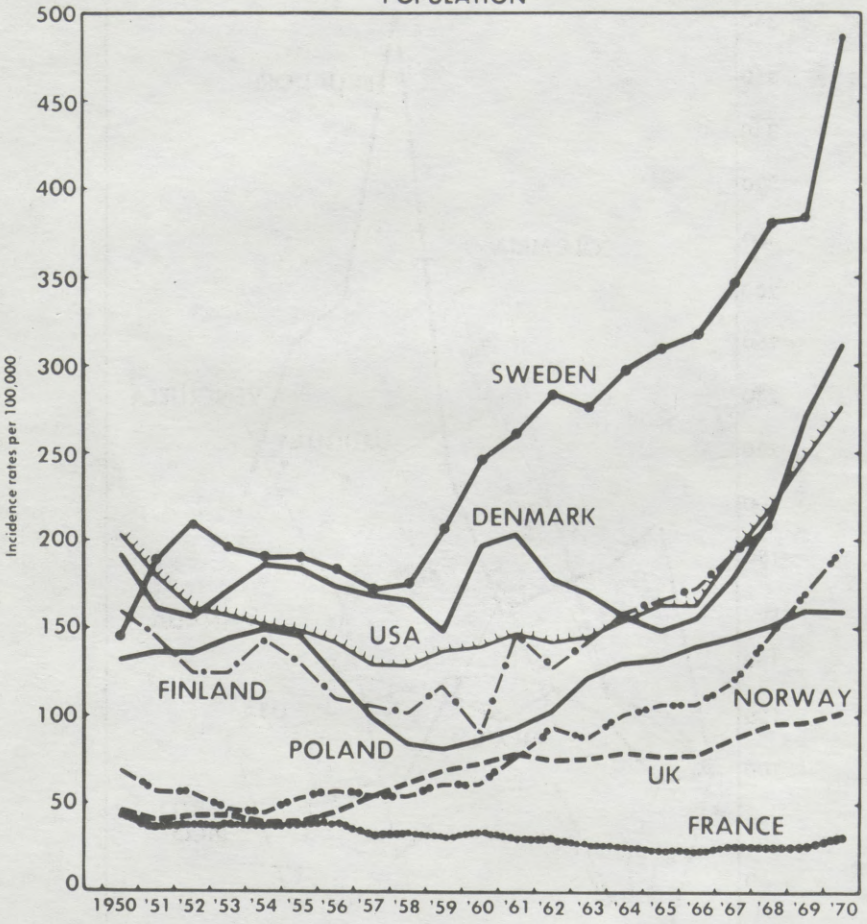


FIGURE 2

FIGURE 3

REPORTED GONORRHEA 1950-1970, INCIDENCE RATES PER 100,000 POPULATION



SEXUALLY TRANSMITTED DISEASES		
	ORGANISM	DISEASE
SPIROCHETES	*T. pallidum* Genital (and ? oral) Spirochetes	Syphilis Balanitis Vaginitis
BACTERIA	Gonococcus *H. ducreyi* Donovania	Gonorrhea Chancroid Granuloma inguinale
VIRUSES	Chlamydia Other viruses	Nongonococcal urethritis Lymphogranuloma venereum Herpes simplex Molluscum contagiosum Condyloma acuminatum
PROTOZOA	*T. vaginalis*	Trichomoniasis
FUNGI	*C. albicans* Epidermophyton inguinale	Monilia Tinea cruris
PARASITES	Acarus scabiei Phthirius pubis	Scabies Pediculosis

FIGURE 4

real disease. Further, they promote promiscuity by permitting a greater number of sexual contacts and thus foster the acquisition of disease.

Another important factor is the growing number of homosexual male patients, who appear to comprise some 10-90 percent of infected patients – particularly those with syphilis – in many venereal disease clinics. Rectal gonorrhea and oral infections, both symptomatic and asymptomatic, have also been reported more frequently in women.

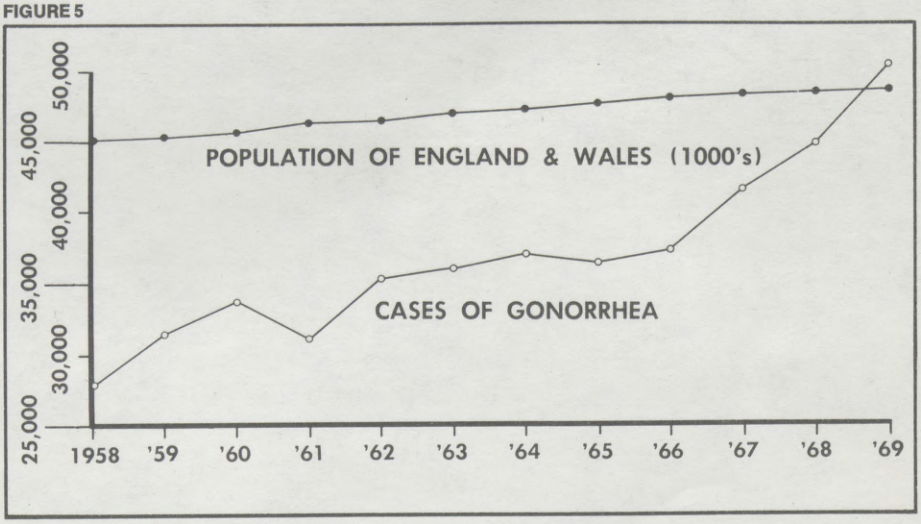
Although VD education in the schools has encouraged young people to seek advice when they believed themselves infected, mere knowledge is not enough, as illustrated by the experience with cigarette consumption. Extremely high VD rates have been reported from both Europe and Africa among the best educated sections of the community, that is, the university students.

Nevertheless, the fact remains that advertisers usually have no trouble in persuading the public of the worth of a product if it fulfills a need. Perhaps if adequate money were forthcoming and the campaign properly sponsored, the desirability of restricting sexual contacts to one at a time might be impressed on people.

There is some evidence that with chemotherapeutic and antibiotic bombardment, both syphilis and gonorrhea are becoming milder diseases, possibly because of lowered virulence of the organism. Patients of both sexes may have relatively mild septicemic lesions, while asymptomatic infections seem to be more common in men.

Treponemal forms of syphilis have been found in

FIGURE 5



lymph nodes, cerebrospinal fluid, and aqueous humor of treated persons. The significance of these organisms is not yet fully clear, as was pointed out in the recent report of the World Health Organization scientific group on treponematosis research. Possibly they are *T. pallidum* of lessened virulence.

A point which is not in dispute is the developing resistance of the gonococcus to antibiotics, particularly penicillin. There is a great variation among countries in this respect, even if one allows for different methods of assessment and reporting and selects only data referring to routine strains. In Africa and the Far East, for example, the situation is far worse than in Northern Europe.

Moreover, there is variation within the same country; for example, the gonococcus is apparently more resistant in San Francisco than in Philadelphia. In the war zones of the Far East, resistance has built up very quickly – the same thing that happened with the sulfonamides nearly 30 years ago, when two fairly closed population groups were having repeated sexual exchanges over long periods of time.

The growth of resistance is not inevitable; occasionally it has been checked, as in Canada, or even reversed, as in Denmark and Greenland. Nevertheless, the trend has been overwhelmingly in the direction of greater resistance, and has necessitated bigger and bigger doses of penicillin.

Today, the single injection of 4.8 million units represents almost the full capacity of the female buttock, and even this amount has been shown to fail in about 30 percent of cases in some parts of the world. Continuing drug research is vitally important if we are to keep pace with a deteriorating situation.

Remedies to the problem of venereal disease can only lie in intensified application of existing techniques, with improved diagnostic tests, health education, and the development of immunizing procedures. The greatest single immediate hope would be the development of a diagnostic serum test for gonorrhea – and a longer-range hope, of course, would be a vaccine.

TABLES & FIGURES

FIGURE 1

COMMUNICABLE DISEASES – NUMBER OF REPORTED CASES
United States, Calendar Year 1970

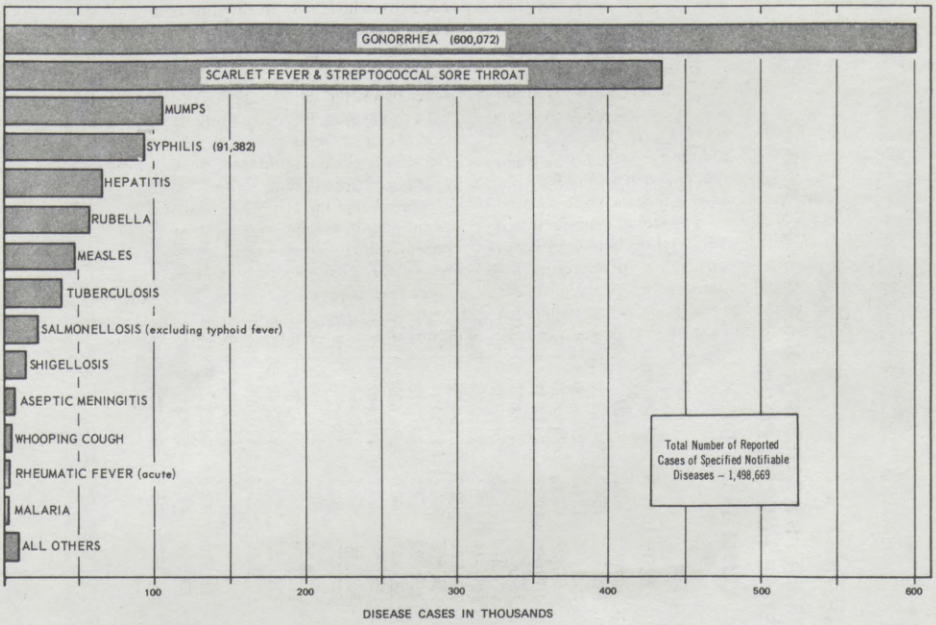


TABLE I

ESTIMATED TOTAL SYPHILIS AND GONORRHEA CASES TREATED

Fiscal 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*

*Projected from results of **1968 National Survey of Venereal Disease Incidence,** conducted by the American Social Health Association.

TABLE II

CASES OF SYPHILIS AND GONORRHEA AND RATES PER 100,000 POPULATION REPORTED BY STATE HEALTH DEPARTMENTS

FISCAL YEARS 1950-1971

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
1969	18,679	9.3	15,399	7.7	59,262	29.5	96,679	48.1	494,227	245.9	512,906	255.2	590,906	294.0
1970	20,186	10.0	15,425	7.7	49,537	24.6	87,934	43.8	573,200	285.2	593,386	295.2	661,134	329.0
1971	23,336	11.5	17,843	8.8	50,429	24.8	94,383	46.5	624,371	307.5	647,707	319.0	718,754	354.0

*Includes Congenital and Other Syphilis
**Excludes Chancroid, Granuloma Inguinale, and Lymphogranuloma Venereum

Source: Public Health Service

78-832 O - 72 - 14

FIGURE 2

PRIMARY AND SECONDARY SYPHILIS
Reported Cases, United States, 1950-1971

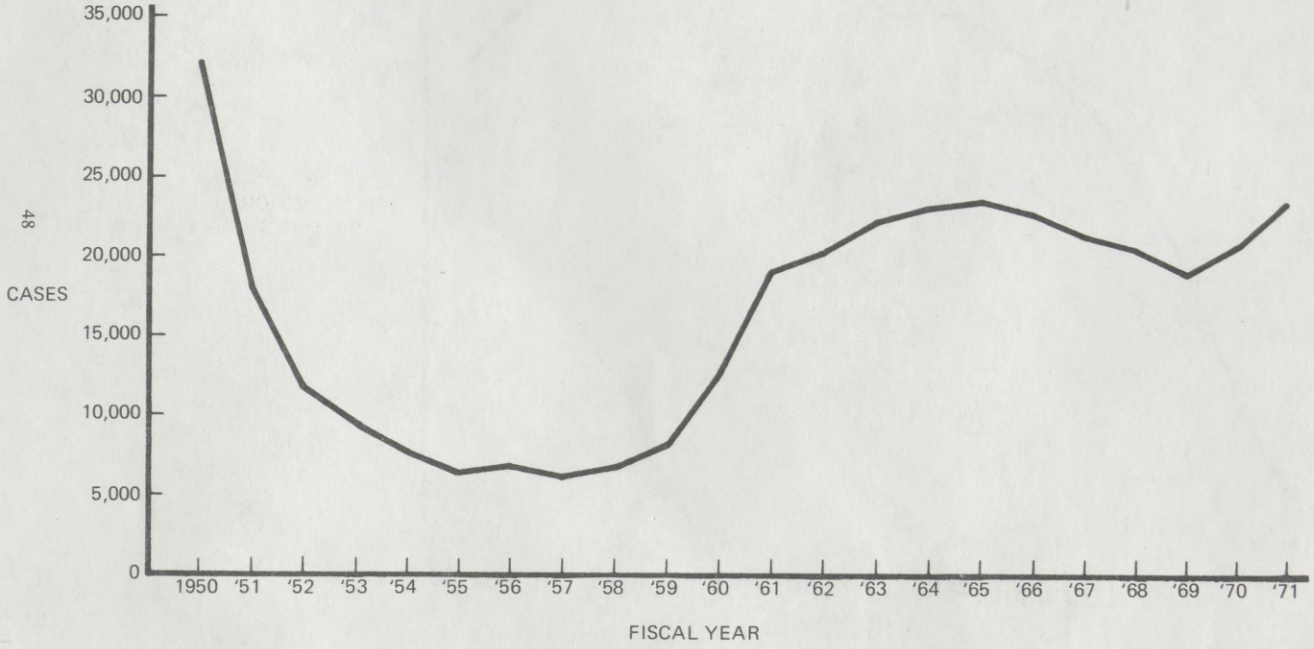


FIGURE 3

GONORRHEA
Reported Cases, United States, 1950-1971

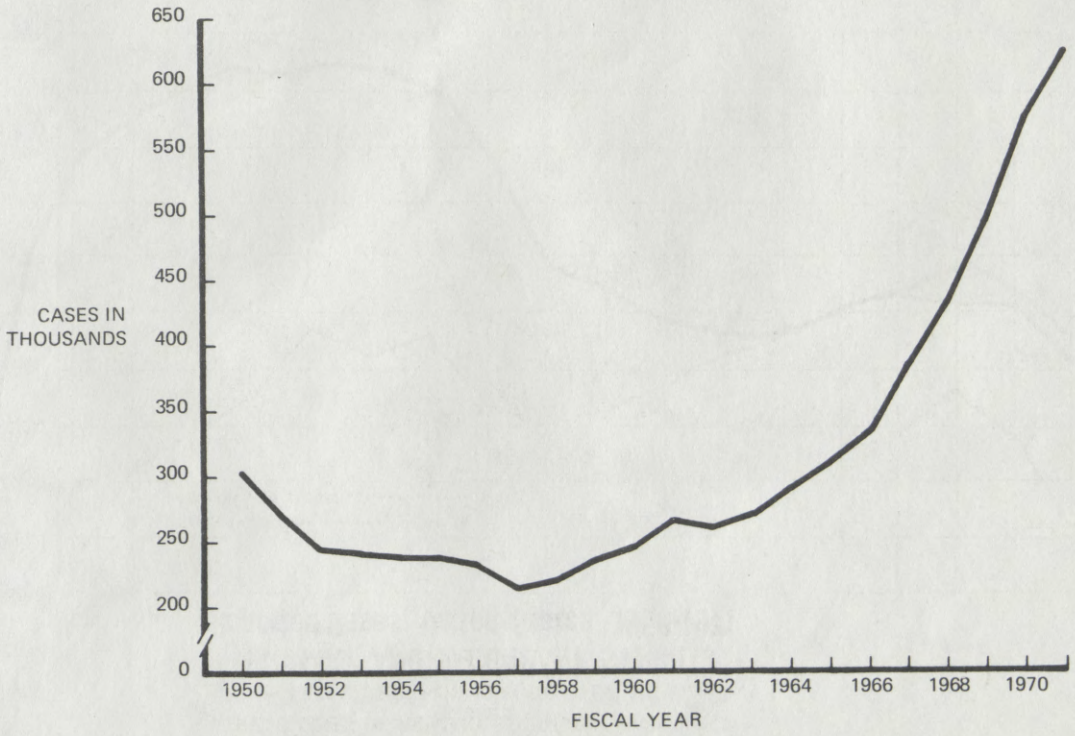


FIGURE 4

TREND LINES OF PRIMARY-SECONDARY AND EARLY LATENT SYPHILIS REPORTED IN U.S. 1954-1971

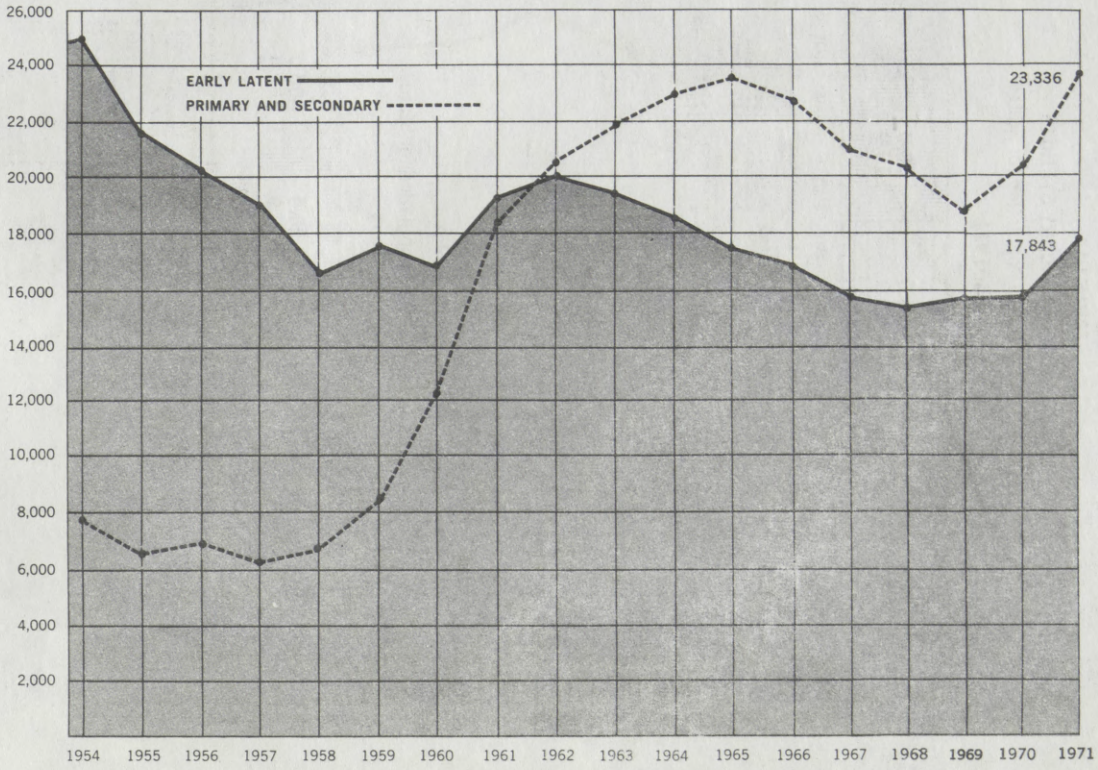
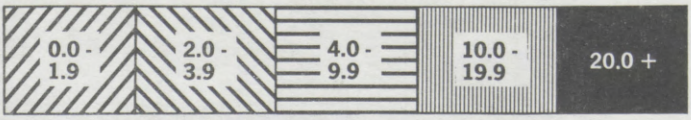


TABLE III

PRIMARY AND SECONDARY SYPHILIS

Case Rates per 100,000 Population for States

Fiscal Year 1971



STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Iowa	0.5	West Virginia	2.0	Ohio	4.1	Delaware	11.8	Louisiana	20.7
Idaho	0.6	South Dakota	2.1	Oklahoma	4.4	South Carolina	12.2	New York	24.3
Vermont	0.7	Colorado	2.7	Alabama	4.8	Maryland	12.5	Florida	24.4
Montana	0.7	Kansas	3.0	Rhode Island	4.9	Mississippi	13.0	Texas	26.1
New Hampshire	0.8	Pennsylvania	3.2	Massachusetts	5.5	Arizona	14.0	Nevada	31.3
Maine	1.0	Hawaii	3.2	Missouri	5.7	California	14.1	Georgia	32.4
North Dakota	1.2	Washington	3.5	Tennessee	6.5	New Mexico	14.1		
Oregon	1.2	Utah	3.9	Indiana	6.7	New Jersey	14.8		
Wisconsin	1.5			Connecticut	7.2	Arkansas	17.0		
Wyoming	1.5			Virginia	7.5				
Minnesota	1.6			Michigan	7.6				
Nebraska	1.6			Alaska	8.5				
				North Carolina	8.6				
				Illinois	8.8				
				Kentucky	9.4				

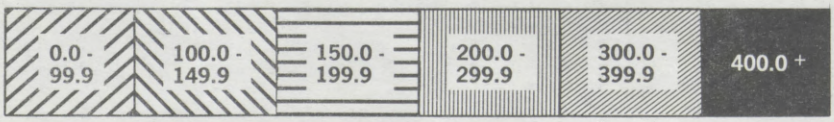
Source: Public Health Service — reported cases only.

TABLE IV

GONORRHEA

Case Rates per 100,000 Population for States

Fiscal Year 1971

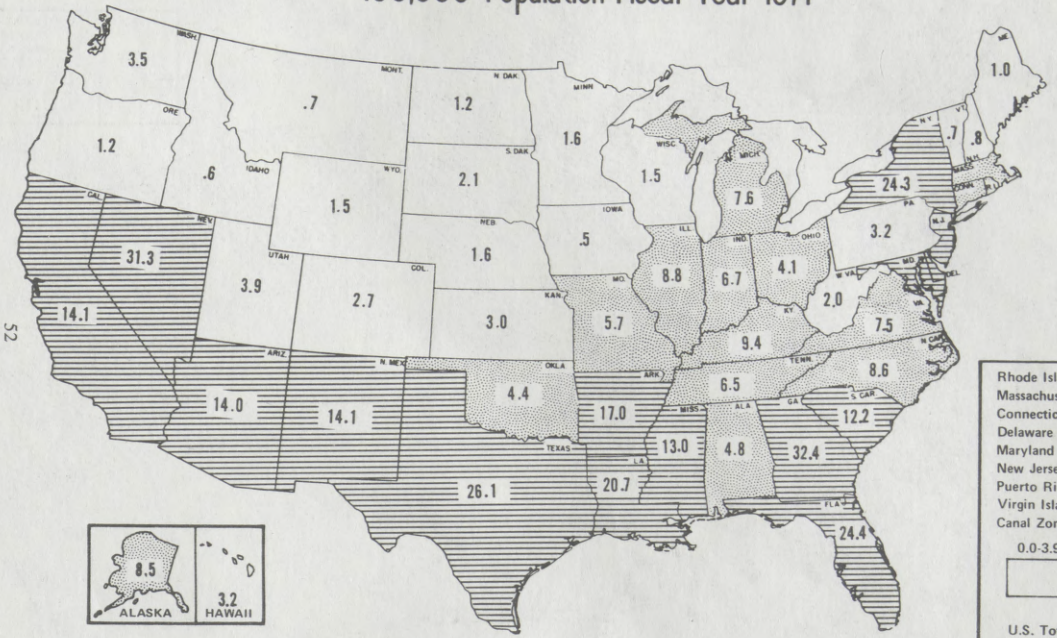


STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
New Hampshire	72.7	Vermont	102.7	Massachusetts	151.6	Hawaii	200.3	Missouri	324.0	Arkansas	400.3
Wyoming	74.2	West Virginia	105.0	Indiana	154.9	Idaho	208.5	Louisiana	337.0	Texas	423.1
Utah	94.1	Maine	111.8	Wisconsin	181.5	Connecticut	213.8	Virginia	345.3	Illinois	440.2
Rhode Island	96.7	Minnesota	127.4	Kentucky	183.4	South Dakota	214.8	Nevada	351.8	Tennessee	468.3
North Dakota	97.7	Montana	134.4	Iowa	199.4	Colorado	227.6	Oregon	359.0	California	500.3
		Pennsylvania	135.6			Michigan	229.3	N. Carolina	366.6	S. Carolina	513.2
		New Jersey	143.5			Arizona	255.7	Maryland	372.5	Georgia	599.7
						Oklahoma	256.1	Mississippi	387.9	Alaska	913.7
						Alabama	258.3	Florida	391.1		
						Washington	261.4				
						Nebraska	267.0				
						Ohio	270.9				
						New Mexico	273.7				
						New York	277.6				
						Kansas	283.1				
						Delaware	283.9				

Source: Public Health Service — reported cases only.

FIGURE 5

PRIMARY & SECONDARY SYPHILIS Case Rates per 100,000 Population-Fiscal Year 1971



Rhode Island	4.9
Massachusetts	5.5
Connecticut	7.2
Delaware	11.8
Maryland	12.5
New Jersey	14.8
Puerto Rico	31.9
Virgin Islands	43.9
Canal Zone	62.9

0.0-3.9 4.0-9.9 10.0-62.9

U.S. Total	11.5*
Median	5.6**

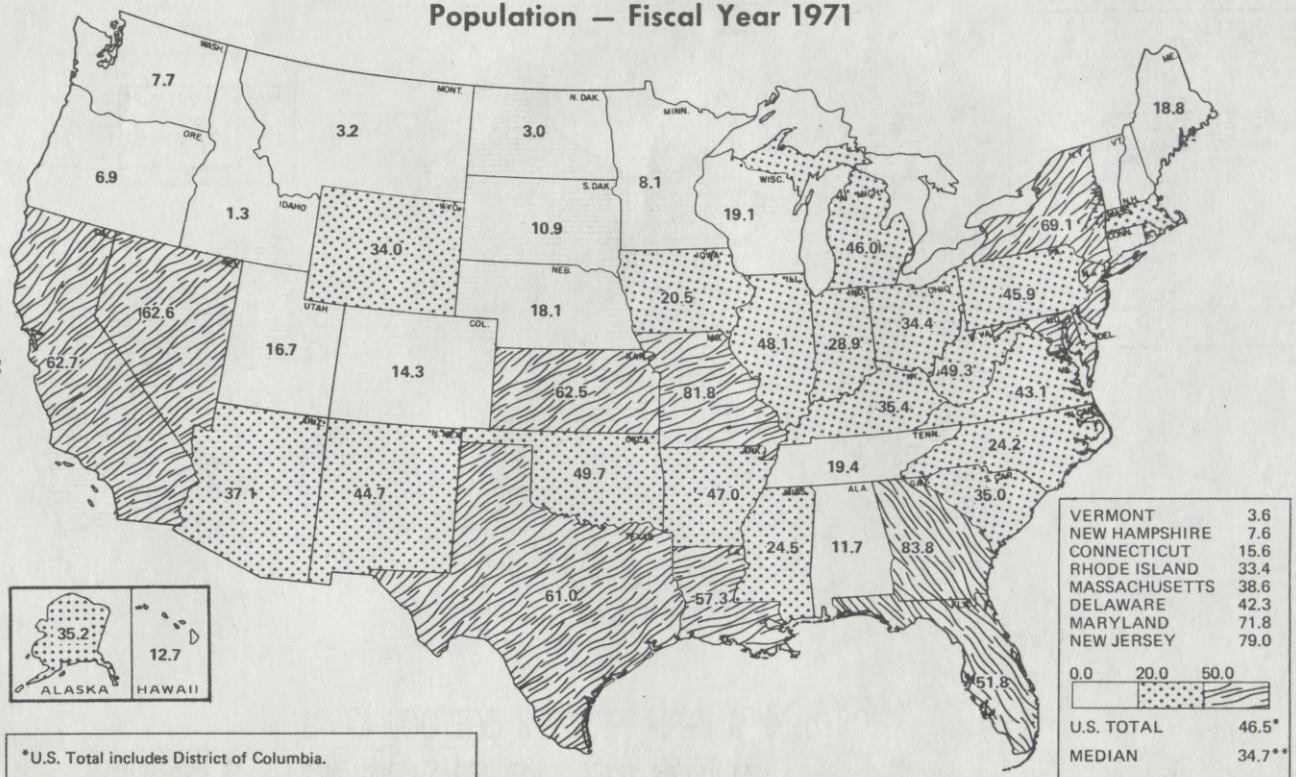
*U.S. Total includes District of Columbia.
**Excludes Puerto Rico, Virgin Islands, and Canal Zone.

TOTAL SYPHILIS

FIGURE 6

Case Rates per 100,000

Population — Fiscal Year 1971



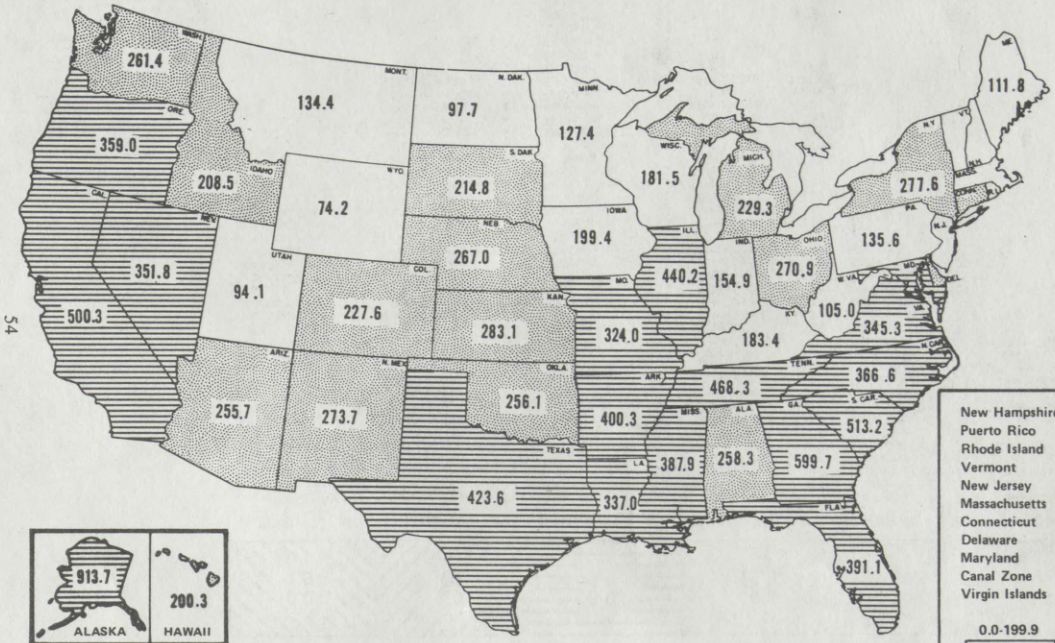
*U.S. Total includes District of Columbia.

**Excludes Puerto Rico, Virgin Islands, and Canal Zone.

FIGURE 7

GONORRHEA

Case Rates per 100,000 Population
Fiscal Year 1971



New Hampshire	72.7
Puerto Rico	79.5
Rhode Island	96.7
Vermont	102.7
New Jersey	143.5
Massachusetts	151.6
Connecticut	213.8
Delaware	283.9
Maryland	372.5
Canal Zone	508.6
Virgin Islands	1136.8

0.0-199.9	200.0-299.9	300.0-1136.8

U.S. Total	307.5*
Median	257.2**

*U.S. Total includes District of Columbia.

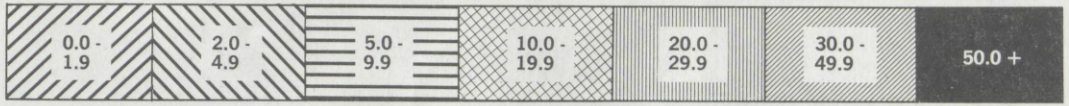
**Excludes Puerto Rico, Virgin Islands, and Canal Zone.

TABLE V

PRIMARY AND SECONDARY SYPHILIS

Case Rates per 100,000 Population for 160 Counties and Cities

Fiscal Year 1971



COUNTY/CITY	RATE
Niagara County, N.Y.	0.4
Des Moines, Iowa	0.5
Duluth, Minn.	0.5
DuPage County, Ill.	0.6
Battle Creek, Mich.	0.7
Lorain, Ohio	0.8
Johnson County, Kansas	0.9
Sioux City, Iowa	1.0
Erie, Pa.	1.1
South Bend, Ind.	1.2
Muskegon, Mich.	1.3
Rensselaer County, N.Y.	1.3
*Provo, Utah	1.4
Chattanooga, Tenn.	1.5
Decatur, Ill.	1.6
Pueblo, Colo.	1.7
Grand Rapids, Mich.	1.7
Monroe, Mich.	1.7
Port Huron, Mich.	1.7
Lane County, Oregon	1.8
*Springfield, Ohio	1.9

COUNTY/CITY	RATE
Baltimore County, Md.	2.2
Salt Lake City, Utah	2.6
Broome County, N.Y.	2.7
Charleston, W.Va.	2.7
Riverside, Calif.	2.8
Burlington County, N.J.	2.8
Macomb County, Mich.	2.9
*Honolulu, Hawaii	3.0
Springfield, Mo.	3.2
Ventura, Cal.	3.4
Omaha, Neb.	3.4
Ulster County, N.Y.	3.5
Montgomery County, Md.	3.6
Pittsburgh, Pa.	3.6
*Portland, Oregon	3.7
*Toledo, Ohio	3.8
Lake County, Ill.	3.9
Suffolk County, N.Y.	3.9
San Jose, Calif.	4.0
Orange County, Cal.	4.1
Lansing, Mich.	4.1
Brevard County, Fla.	4.3
Buffalo, N.Y.	4.4
Kern County, Cal.	4.5
*Canton, Ohio	4.5
Sacramento, Cal.	4.8
Birmingham, Ala.	4.9
San Bernardino, Cal.	4.9

COUNTY/CITY	RATE
Abilene, Texas	5.0
Peoria, Ill.	5.1
Gulfport, Miss.	5.2
*Albuquerque, N.M.	5.2
Rockland County, N.Y.	5.2
*Portsmouth, Va.	5.4
Wichita, Kansas	5.5
*Utica, N.Y.	5.5
Asheville, N.C.	5.5
Nassau County, N.Y.	5.6
Nashville, Tenn.	5.7
Stockton, Cal.	5.8
*Camden, N.J.	5.9
Mobile, Ala.	6.0
Denver, Colo.	6.2
*Minneapolis, Minn.	6.5
*Milwaukee, Wisc.	6.5
Albany, N.Y.	6.7
Seattle, Wash.	6.7
*Yonkers, N.Y.	6.8
Tulsa, Okla.	6.8
Knoxville, Tenn.	7.1
Pensacola, Fla.	7.2
*St. Paul, Minn.	7.2
Rockford, Ill.	7.3
San Diego, Cal.	7.5
Vallejo, Cal.	7.5
Montgomery, Ala.	7.7
Tucson, Ariz.	7.7
*Norfolk, Va.	7.7
*Bridgeport, Conn.	7.8
*Charlotte, N.C.	7.8
Oklahoma City, Okla.	8.0
*Stamford, Conn.	8.3
Orange County, N.Y.	8.5
Rochester, N.Y.	8.7
*Cleveland, Ohio	8.7
*Akron, Ohio	9.0
Modesto, Cal.	9.2
Jefferson Parish, La.	9.3
*Kansas City, Mo.	9.4
*Newport News, Va.	9.4

COUNTY/CITY	RATE
*Syracuse, N.Y.	10.0
*Philadelphia, Pa.	10.0
Fresno, Cal.	10.4
*Columbus, Ga.	10.4
Phoenix, Ariz.	10.8
San Mateo, Cal.	10.9
*Columbus, Ohio	11.2
*Long Beach, Cal.	11.4
*Pasadena, Cal.	11.5
St. Petersburg, Fla.	11.9
Durham, N.C.	11.9
Oakland, Cal.	12.6
Kansas City, Kansas	12.6
Fayetteville, N.C.	13.1
Lake Charles, La.	13.5
Orlando, Fla.	13.6
*Cincinnati, Ohio	13.6
*New Haven, Conn.	14.0
Corpus Christi, Texas	14.4
Raleigh, N.C.	14.6
Greensboro, N.C.	14.7
Flint, Mich.	16.0
*Providence, R.I.	16.6
*Lubbock, Texas	17.7
Monterey County, Cal.	17.8
Memphis, Tenn.	18.6
Austin, Texas	19.3
Daytona Beach, Fla.	19.6
Atlantic County, N.J.	19.6

COUNTY/CITY	RATE
Los Angeles, Cal.	20.0
Jacksonville, Fla.	21.4
San Antonio, Texas	21.6
*Elizabeth, N.J.	22.0
Berkeley, Cal.	22.1
Baton Rouge, La.	22.6
Tampa, Fla.	22.7
*Youngstown, Ohio	23.1
*Chicago, Ill.	23.3
*St. Louis, Mo.	24.1
San Benito, Texas	26.4
Arlington, Va.	27.4
Polk County, Florida	27.5
Louisville, Kent.	27.9
Ft. Lauderdale, Fla.	28.0
El Paso, Texas	28.5
*Richmond, Va.	29.4

COUNTY/CITY	RATE
*Jersey City, N.J.	30.1
*Detroit, Mich.	30.2
Indianapolis, Ind.	30.5
*Boston, Mass.	33.0
Savannah, Ga.	33.4
Fort Worth, Texas	33.7
*Baltimore, Md.	36.7
*New Orleans, La.	40.0
Houston, Texas	43.6
Miami, Fla.	43.7
*Trenton, N.J.	45.1
Las Vegas, Nevada	45.7
*Dayton, Ohio	46.3
*Paterson, N.J.	47.4
*New York, N.Y.	48.8

COUNTY/CITY	RATE
Shreveport, La.	52.1
Dallas, Texas	67.7
*Hartford, Conn.	71.7
Washington, D.C.	77.0
San Francisco, Cal.	81.4
Atlanta, Ga.	87.6
Augusta, Ga.	92.3
*Newark, N.J.	124.0

*City data
Cities without (*) report county data.

Source: Joint Statement questionnaire and Public Health Service **VD Statistical Letter,** Issue No. III.

TABLE VI

GONORRHEA

Case Rates per 100,000 Population for 156 Counties and Cities

Fiscal Year 1971

0.0 - 99.9	100.0 - 199.9	200.0 - 299.9	300.0 - 399.9	400.0 - 499.9	500.0 - 699.9	700.0 - 1,199.9	1,200.0 +

COUNTY/CITY	RATE
Burlington County, N.J.	11.4
Orange County, N.Y.	29.6
DuPage County, Ill.	29.7
Suffolk County, N.Y.	34.4
Macomb County, Mich.	39.2
*Provo, Utah	48.2
Lake County, Ill.	49.1
Rockland County N.Y.	49.5
*Springfield, Mo.	51.3
San Benito, Texas	54.1
Johnson County, Kansas	56.7
Nassau County, N.Y.	59.7
Niagara County, N.Y.	63.1
Erie, Pa.	63.5
Montgomery County, Md.	65.2
Chautauqua County, N.Y.	66.6
Atlantic County N.J.	67.3
Monroe, Mich.	82.6
Duluth, Minn.	83.7
Rensselaer County, N.Y.	85.1
Ulster County, N.Y.	87.3
Prince Georges County, Md.	99.7

COUNTY/CITY	RATE
Pueblo, Colo.	112.3
*Yonkers, N.Y.	113.9
Salt Lake City, Utah,	122.7
*Camden, N.J.	129.2
Lorain, Ohio	139.2
Springfield, Ohio	152.5
Ventura, Cal.	152.6
Pittsburgh, Pa.	162.3
Brevard County, Fla.	162.4
*Canton, Ohio	182.9
San Antonio, Texas	184.4
Port Huron, Mich.	184.6
Baton Rouge, La.	196.6

COUNTY/CITY	RATE
Lake Charles, La.	206.5
Arlington, Va.	213.5
Broome County, N.Y.	215.6
*Jersey City, N.J.	216.5
Buffalo, N.Y.	216.8
Tucson, Ariz.	222.5
Minneapolis, Minn.	228.3
Riverside, Calif.	235.9
Abilene, Texas	237.2
Solano County, Cal.	242.5
*Utica, N.Y.	254.9
Tulsa, Okla.	257.2
Jefferson County La.	259.8
*Honolulu, Hawaii	270.5
El Paso, Texas	277.0
Monterey County, Cal.	280.6
Ft. Lauderdale, Fla,	284.4
Corpus Christi, Texas	289.9
*Paterson, N.J.	293.1
Phoenix, Ariz.	293.6

COUNTY/CITY	RATE
*Stamford, Conn.	302.4
Charleston, W.Va.	309.7
San Bernardino, Cal.	311.6
Orange County, Cal.	314.0
San Jose, Cal.	319.9
Sioux City, Iowa	321.1
Fresno, Cal.	321.7
San Diego, Cal.	328.8
Austin, Texas	333.8
Greensboro, N.C.	339.0
Grand Rapids, Mich.	341.8
Miami, Fla.	342.9
S. Bend, Ind.	344.5
Rockford, Ill.	346.5
Flint, Mich	357.6
*Providence, R.I.	357.7
Knoxville, Tenn.	362.1
Albuquerque, N.M.	371.8
*Bridgeport, Conn.	372.7
Albany, N.Y.	373.3
*Elizabeth, N.J.	376.5
*Toledo, Ohio	385.5
San Mateo, Cal.	390.2
Stockton, Cal.	391.3
Daytona Beach, Fla.	391.7
*St. Paul, Minn.	394.3
Lane County, Ore.	395.9
Lansing, Mich.	396.1
*Cincinnati, Ohio	397.4

COUNTY/CITY	RATE
Bakersfield, Cal.	409.8
Rochester, N.Y.	411.3
*Muskegon, Mich.	413.8
Las Vegas, Nev.	423.9
Decatur, Ill.	428.5
Orlando, Fla.	432.0
Wichita, Kansas	440.7
Louisville, Kent.	443.5
Seattle, Wash.	451.4
*New York, N.Y.	452.5
Mobile, Ala.	456.0
Asheville, N.C.	461.3
Gulfport, Miss.	462.8
Oakland, Cal.	472.6
Indianapolis, Ind.	495.6

COUNTY/CITY	RATE
*Peoria, Ill.	512.2
Sacramento, Cal.	516.8
Oklahoma City, Okla.	518.5
Raleigh, N.C.	523.3
*Youngstown, Ohio	528.1
Shreveport, La.	535.7
*Detroit, Mich.	536.9
Battle Creek, Mich.	538.9
Jacksonville, Fla.	541.4
Birmingham, Ala.	546.7
Modesto, Cal.	562.8
*Philadelphia, Pa.	563.3
Chattanooga, Tenn.	566.1
Los Angeles, Cal.	566.7
Pensacola, Fla.	578.8
Nashville, Tenn.	606.3
Fayetteville, N.C.	614.1
Fort Worth, Texas	625.5
*Newport News Va.	628.1
Denver, Colo.	637.8
*Long Beach, Cal.	642.7
Omaha, Neb.	694.2

COUNTY/CITY	RATE
*Columbus, Ohio	713.6
*Des Moines, Iowa	717.3
*New Orleans, La.	727.6
Montgomery, Ala.	738.6
Dayton, Ohio	793.4
Tampa, Fla.	821.5
*Boston, Mass.	827.1
*Houston, Texas	827.4
*Milwaukee, Wisc.	835.4
*Akron, Ohio	908.0
*Syracuse, N.Y.	919.4
*Portland, Ore.	934.2
*Trenton, N.J.	936.5
*Pasadena, Cal.	987.7
*St. Louis, Mo.	997.8
*Portsmouth, Va.	1,076.5
*Kansas City, Mo.	1,112.9
*Chicago, Ill.	1,122.5
Kansas City, Kan.	1,130.1
Dallas, Texas	1,145.2

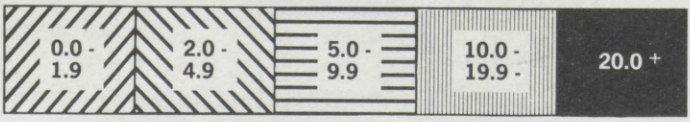
COUNTY/CITY	RATE
*Cleveland, Ohio	1,230.2
*Baltimore, Md.	1,237.4
Savannah, Ga.	1,302.9
*Richmond, Va.	1,348.9
*Newark N.J.	1,355.2
*Norfolk, Va.	1,357.5
*New Haven, Conn.	1,393.4
*Hartford, Conn.	1,434.0
Washington, D.C.	1,515.2
Memphis, Tenn.	1,540.7
Charlotte, N.C.	1,557.8
Durham, N.C.	1,670.6
*Berkeley, Cal.	1,782.7
San Francisco. Cal.	2,066.9
Atlanta, Ga.	2,510.3

*City Data

Cities without (*) report county data.

Source: Joint Statement questionnaire and Public Health Service **VD Statistical Letter**, Issue No. 111.

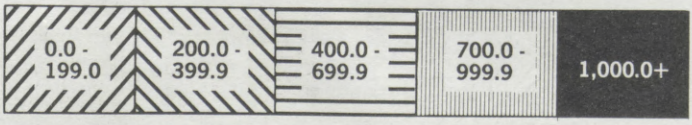
TABLE VII
15-19 YEAR AGE GROUP
Case Rates for P&S Syphilis
Calendar Year 1970



STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
N. Hampshire	0.0	Maine	2.2	Pennsylvania	5.5	Oklahoma	10.0	Arizona	20.4
Vermont	0.0	Minnesota	2.5	Ohio	6.1	Michigan	11.4	New Jersey	22.1
Montana	0.0	Colorado	2.9	Kansas	6.3	Virginia	11.4	Mississippi	23.6
N. Dakota	0.0	Wisconsin	3.6	W. Virginia	6.4	Alabama	11.6	New Mexico	24.3
Wyoming	0.0	Nebraska	4.4	Massachusetts	6.7	Illinois	11.8	Maryland	25.4
Hawaii	0.0	S. Dakota	4.5	Rhode Island	8.3	Missouri	12.8	New York	30.0
Alaska	0.0			Connecticut	8.7	California	13.4	S. Carolina	30.1
Iowa	0.8			Utah	9.2	N. Carolina	16.4	Florida	52.5
Idaho	1.4			Tennessee	9.9	Kentucky	16.5	Texas	54.4
Oregon	1.5					Indiana	18.4	Louisiana	56.7
Washington	1.9							Delaware	58.0
								Arkansas	59.6
								Nevada	74.4
								Georgia	77.8

Source: Public Health Service — reported cases only.
Age-specific case rates per 100,000 population.

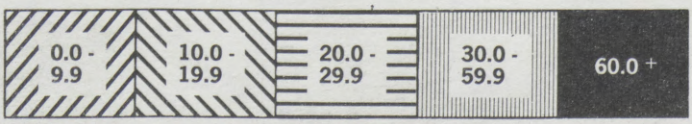
TABLE VIII
15-19 YEAR AGE GROUP
Case Rates for Gonorrhea
Calendar Year 1970



STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Wyoming	142.4	Utah	216.5	W. Virginia	400.6	Oklahoma	756.8	Nevada	1,020.5
N. Hampshire	154.0	Vermont	226.8	S. Dakota	431.8	Kansas	780.1	Texas	1,025.8
N. Dakota	161.3	Minnesota	254.7	Idaho	453.4	Ohio	789.2	Louisiana	1,044.4
Maine	178.3	Hawaii	290.5	Conn.	463.4	Arkansas	837.1	S. Carolina	1,058.7
Montana	182.6	Mass.	335.4	New York	465.9	Alabama	840.4	Illinois	1,064.7
Rhode Island	190.3	New Jersey	372.5	Kentucky	500.6	Delaware	850.0	N. Carolina	1,141.2
		Pennsylvania	385.9	Colorado	535.9	Missouri	909.4	Miss.	1,141.5
				Indiana	541.9	Virginia	924.0	Alaska	1,180.0
				Wisconsin	542.5	Oregon	999.5	California	1,211.9
				Arizona	570.7			Maryland	1,245.1
				Michigan	585.5			Tenn.	1,367.8
				Iowa	600.0			Florida	1,404.1
				N. Mexico	603.7			Georgia	1,558.4
				Washington	637.2				
				Nebraska	692.7				

Source: Public Health Service — reported cases only.
Age-specific case rates per 100,000 population.

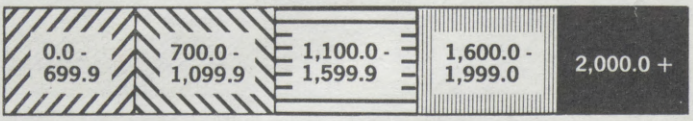
TABLE IX
20-24 YEAR AGE GROUP
Case Rates for P&S Syphilis
Calendar Year 1970



STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Idaho	0.0	Wisconsin	10.7	Connecticut	20.2	N. Carolina	30.4	Arkansas	64.8
N. Dakota	0.0	Utah	11.1	Oklahoma	21.4	Indiana	31.2	Florida	81.5
New Hampshire	1.9	Alaska	12.5	Virginia	21.4	Illinois	35.4	New York	82.4
Montana	2.1	Minnesota	12.8	Tennessee	22.3	California	36.1	Louisiana	89.7
S. Dakota	2.3	Wyoming	13.0	Missouri	25.8	Mississippi	41.1	Texas	97.2
Vermont	2.9	Pennsylvania	14.4	Massachusetts	26.1	Maryland	43.4	Nevada	105.1
Iowa	3.1	Kansas	15.5	Kentucky	26.5	New Mexico	46.6	Georgia	123.3
Washington	5.0	Ohio	16.1	Michigan	27.2	New Jersey	47.7		
Oregon	5.8	Alabama	19.2	Rhode Island	27.9	S. Carolina	51.0		
Hawaii	6.5					Arizona	54.4		
Nebraska	6.8					Delaware	57.1		
W. Virginia	6.9								
Maine	7.3								
Colorado	8.2								

Source: Public Health Service — reported cases only.
Age-specific case rates per 100,000 population.

TABLE X
20-24 YEAR AGE GROUP
Case Rates for Gonorrhea
Calendar Year 1970



STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
N. Dakota	372.1	Pennsylvania	703.7	Delaware	1,161.9	Virginia	1,624.1	Texas	2,116.8
N. Hampshire	405.6	New Jersey	714.3	Oklahoma	1,164.6	N. Mexico	1,652.1	Tennessee	2,124.3
Wyoming	421.7	Kentucky	738.0	Alabama	1,168.2	Arkansas	1,715.8	S. Carolina	2,349.0
Rhode Island	433.8	Massachusetts	832.6	Idaho	1,215.7	Miss.	1,808.6	Illinois	2,564.1
W. Virginia	480.0	Indiana	853.4	Iowa	1,230.6	Missouri	1,812.6	California	2,596.3
Utah	500.0	Hawaii	901.6	Michigan	1,295.9	Maryland	1,818.9	Georgia	2,700.0
Montana	579.2	Arizona	1,033.8	Nebraska	1,363.1	Florida	1,845.8	Alaska	3,254.2
Maine	597.7	Connecticut	1,046.6	Washington	1,371.8	Nevada	1,876.9		
Vermont	691.2	Wisconsin	1,050.3	Ohio	1,408.2	Oregon	1,949.0		
Minnesota	691.4	S. Dakota	1,058.1	New York	1,412.2				
		Colorado	1,085.3	Kansas	1,501.9				
				N. Carolina	1,559.8				
				Louisiana	1,598.9				

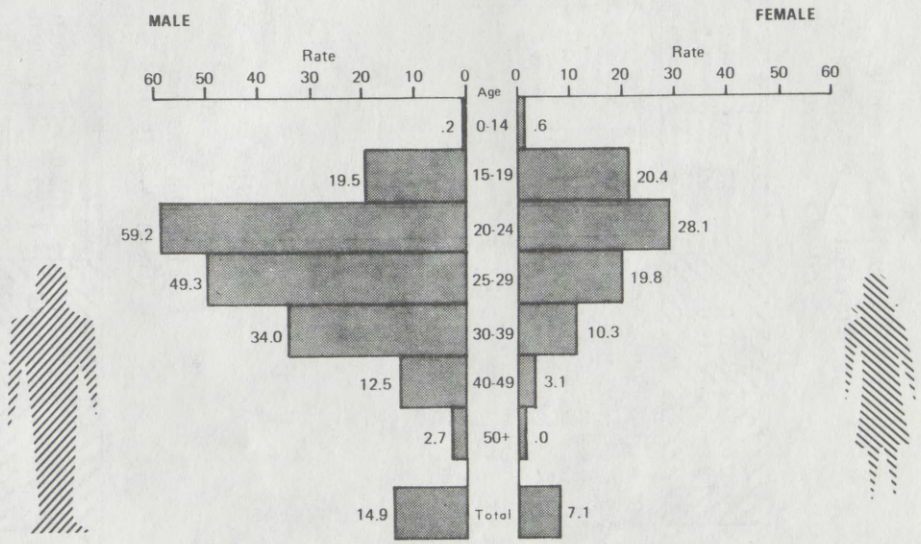
Source: Public Health Service — reported cases only.
Age-specific case rates per 100,000 population.

FIGURE 8

PRIMARY AND SECONDARY SYPHILIS

Age-Specific Case Rates* By Sex

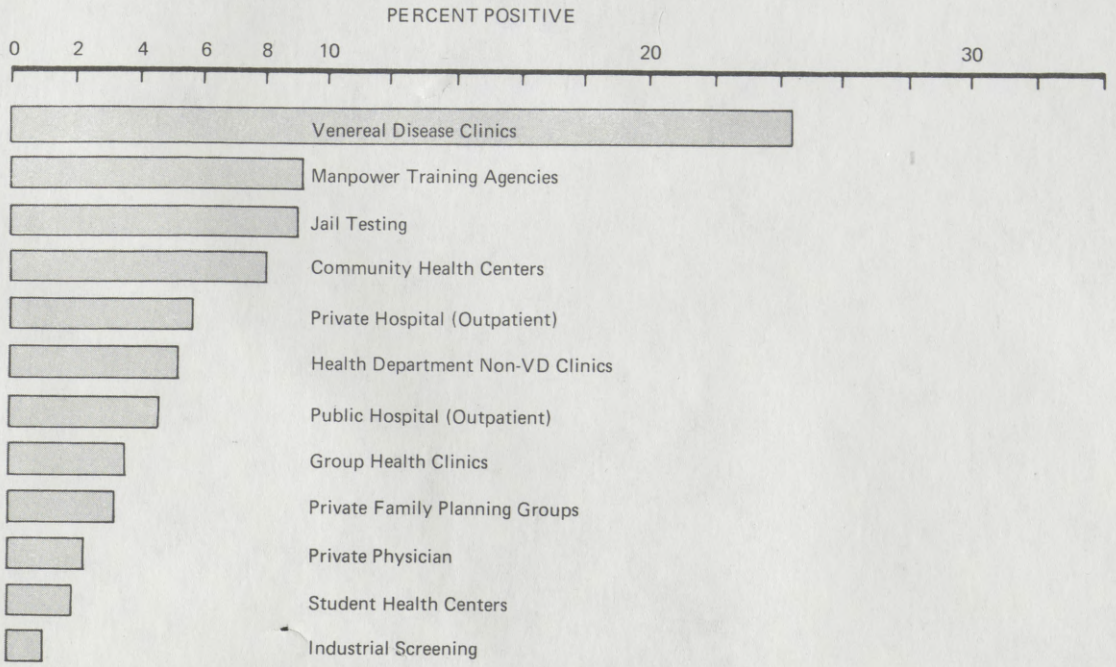
United States—Calendar Year 1970



*Cases per 100,000 Population

FIGURE 9

GONORRHEA SCREENING SUMMARY (FEMALES)
% Positive by Type of Facility Performing Test – FY 1971



NOTE: Results are based on 305,929 tests for gonorrhea.