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COMMUNICABLE DISEASE CONTROL AMENDMENTS ACT OF 1972

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-SECOND CONGRESS

SECOND SESSION

ON

S. 3442

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND THE AUTHORIZATION FOR GRANTS FOR COMMUNICABLE DISEASE CONTROL AND VACCINATION ASSISTANCE, AND FOR OTHER PURPOSES

S. 3187

TO AMEND THE PUBLIC HEALTH SERVICE ACT SO AS TO PROVIDE FOR THE PREVENTION AND CONTROL OF VENEREAL DISEASE

APRIL 10, 1972

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

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COMMUNICABLE DISEASE CONTROL AMENDMENTS ACT OF 1972

MONDAY, APRIL 10, 1972

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

The subcommittee met, pursuant to notice, at 9:40 a.m., in room 4232, New Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Eagleton, Hughes, Schweiker, Javits, and Dominick.

Staff members present: LeRoy G. Goldman, professional staff member; and Jay B. Cutler, minority counsel.

Senator KENNEDY. The subcommittee will come to order. Today, the Senate Subcommittee on Health holds hearings on legislative proposals which concern the prevention and control of communicable diseases. Such diseases affect millions of Americans each year and especially present a serious threat to the health of the Nation's children, a most vulnerable population. As chairman of the Health Subcommittee, I am most concerned that the Nation's health care system respond to the health care needs of all Americans in the most effective and efficient means possible. The efforts to prevent and control communicable diseases reflect the strengths and weaknesses of our present health care system. Communicable diseases were the leading causes of death at the turn of the century. In 1900, influenza, tuberculosis, and gastritis accounted for nearly a third of all deaths. However, outstanding medical research achievements have today dramatically reduced the mortality rates for infectious diseases. Many effective vaccines have been developed which could eradicate several of our common communicable diseases. Effective drugs are now available to treat the acute infections and thereby prevent serious medical complications. We have the means available and yet there are serious gaps in the application of such effective remedies to eradicate many communicable diseases.

We are currently committing significant Federal support to scientific research for effective means to prevent and control heart disease, cancer, and stroke, the three leading causes of death in America today. Yet such effective approaches are available for many communicable diseases. It is imperative that the Federal Government play a leadership role in implementing the research tools available. Unfortunately, there often has not been a consistent and coordinated plan to control communicable diseases. Inadequacies in health care delivery have resulted in unnecessary infections with needless human suffering and economic loss.

The cases reported for venereal diseases represent alarming increases which this Nation has not faced since the post-World War II period. Gonorrhea and syphilis are clearly approaching epidemic proportions and there is no indication that the present escalating trend will be abated in the near future.

Gonorrhea is the most prevalent reportable communicable disease in the Nation. In 1971, 624,000 cases were reported. If unreported cases were included, cases would total more than 2,500,000! In the past 4 years gonorrhea has increased on the average of 15 to 16 percent per year. Some cities have had nearly 50-percent increases in the past year. Of special concern are the estimated 800,000 women with asymptomatic cases of gonorrhea who constitute a silent reservoir of infection. Prenatal clinic exams have shown one out of 12 pregnant women infected with gonorrhea who were unaware of the infection. Serious complications can result to the newborn of an infected mother (such as severe eye infections). Up to 10 percent of women infected may develop severe infections which can cause infertility and may warrant abdominal surgery.

Syphilis with declining rates of infection for 4 consecutive years (1965–69) rose 8.1 percent in 1970 and 8.9 percent in 1971. Reported cases for 1971 were 23,000 with estimates of more than 95,000 if unreported cases are included. Without prompt diagnosis and treatment, severe medical disabilities may develop years after the initial infection. Syphilis can cause blindness, paralysis and insanity. Institutional care for the syphilitic insane amounts to more than $40 million per year.

As a cosponsor of Senate bill 3187 which was introduced by Senator Javits for prevention and control of venereal disease, I believe the Federal Government must respond to this health crisis. There must be a Federal commitment to launch a national campaign in cooperation with State and local agencies, public and private, to develop better programs to detect and treat infected individuals and educate the public to recognize the disease and seek treatment. The upward spiral must be halted if we are to prevent serious medical problems caused by these diseases. Basic research must also be supported to find more effective means of prevention.

Despite tremendous strides in vaccination and immunization programs there continue to be serious gaps in levels of immunization for the Nation's children. In 1964 87.6 percent of children between the ages of 1 and 4 were immunized against polio; 1971 levels are 67.3 percent. Comparable immunization levels in 1971 include: measles, 61.4 percent; rubella, 51.2 percent and diphtheria-pertussis-tetanus, 78.7 percent. Overall these figures indicate an increase from 1970 levels, but still they demonstrate a serious lack of protection for many children. Furthermore, comparable levels are lower for the inner city and economically disadvantaged children.

Because of inadequate immunization, reported cases of such diseases continue. There were 75,000 cases of measles reported in 1971 in contrast to 47,000 for 1970. The reported cases of rubella have decreased from 56,500 cases in 1970 to 44,000 cases in 1971. Vigorous immunization programs have significantly reduced the impact of these diseases because of available vaccines, but a concerted effort must continue to immunize all children. Each disease may cause serious

medical complications, and it is foolish to gamble with a child's health when vaccines are effective for prevention. The paralysis of polio is well known. Measles may cause encephalitis and mental retardation. Rubella in the 1964–65 epidemic resulted in 20,000 brain damaged children with estimated costs of rehabilitation put at more $2 billion. Diphtheria which continues to occur in sporadic outbreaks can result in heart and brain damage and death by suffocation. Mortality rates for tetanus are as high as 70 percent. Whooping cough may readily cause death especially to the child under 1 year of age and also can produce convulsions, brain damage, and chronic lung disease. With an effective immunization available for the susceptible woman one must also include the effects of Rh incompatibility on the unborn baby; namely, death before birth, or serious jaundice with the possibility of severe brain damage after birth.

In the health area generally we still have few measures which can produce primary prevention of disease. Yet such tools are available for several communicable diseases. Effective vaccines are available to eradicate many infections which wreak such havoc on children. There must be a Federal commitment to universal immunization for all children. If we can eradicate smallpox, we can also eradicate such diseases as polio, measles, and rubella. Support must not falter for such programs. Tuberculosis which had continued to decline significantly now appears to be declining less rapidly and may actually be increasing in the inner city population. Decreased funding for tuberculosis programs contributes to such a result.

I have introduced Senate bill 3442 which extends legislative authority for communicable diseases prevention and control under section 317 of the Public Health Service Act. This legislation is essential to mandate a concerted attack on a broad spectrum of communicable diseases. This legislation will increase the effort for coordinated plans and programs to prevent and control communicable diseases by research, immunization, treatment, and public education.

In 1962, when President Kennedy first proposed a vaccination assistance program in a special message to Congress, he said:

"There is no longer any reason why American children should suffer from polio, diphtheria, whooping cough, or tetanus diseases which can cause death or serious consequences throughout a lifetime, which can be prevented, but which still prevail in too many cases." Our national communicable disease programs have in many instances significantly reduced the toll these diseases exact in human and economic terms. Yet much more needs to be done. These hearings shall provide the impetus for continued congressional commitment to communicable disease prevention and control. Our goal must be (1) universal immunization of children to eradicate those communicable diseases for which vaccines are available; (2) expanded program support to halt the cycle of infection for such diseases as tuberculosis, gonorrhea, and syphilis; (3) continued basic research to develop new vacines and other effective treatment; and (4) program support for public education.

I am committed to such a goal.

(A copy of the bills S. 3442 and S. 3187 follow:)

92d CONGRESS
2d Session

S. 3442

IN THE SENATE OF THE UNITED STATES

March 29, 1972

Mr. Kennedy (for himself, Mr. Cranston, Mr. Eagleton, Mr. Hughes, Mr. Javits, Mr. Mondale, Mr. Pell, Mr. Randolph, Mr. Schweiker, Mr. Stevenson, and Mr. Williams) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Communicable Disease
4 Control Amendments Act of 1972".
5 Sec. 2. (a) Section 317 (a) of the Public Health Serv-
6 ice Act is amended to read as follows: "There are authorized
7 to be appropriated $90,000,000 for the fiscal year ending
8 June 30, 1972; $90,000,000 for the fiscal year ending June
9 30, 1973, and each of the next four succeeding fiscal years

1 to enable the Secretary to make grants to States, and in
2 consultation with the State health authority to agencies and
3 political subdivisions of the States, under this subsection. In
4 the awarding of such grants, the Secretary shall give con-
5 sideration to the relative extent of the problems relating to
6 one or more of the diseases referred to in subsection (b) (1)
7 and to the design of the public health program to assure
8 effective performance in preventing and controlling such
9 diseases. Such grants may be used for meeting the cost of
10 communicable disease control programs and their attendant
11 laboratory services, including the cost of studies to determine
12 the communicable disease control needs of the communities
13 and the best means of meeting such needs.

14 (b) (1) Subsection (b) of such section is amended by
15 striking out the word "subsection" and inserting in lieu
16 thereof "section".

17 (2) Subsection (b) (1) of such section is amended by
18 striking out the phrase "on the recommendation of the Na-
19 tional Advisory Health Council".

20 (c) Such section, as amended by this Act, is further
21 amended by adding at the end thereof the following new
22 subsection:

23 "(h) (1) The Secretary is authorized to make grants
24 to, and enter into contracts with, public and private non-
25 profit agencies, organizations and institutions for the pur-

1 pose of making the citizens of the United States aware of
2 the consequences of the diseases described in subsection
3 (b) (1) and the programs available which will avert such
4 consequences.
5 (2) For the purpose of carrying out this subsection,
6 there are authorized to be appropriated $5,000,000 for the
7 fiscal year ending June 30, 1973, and each of the next four
8 succeeding fiscal years."

92d CONGRESS
2d Session

S. 3187

IN THE SENATE OF THE UNITED STATES

February 17, 1972

Mr. Javits (for himself, Mr. Kennedy, Mr. Williams, Mr. Dominick, Mr. Brooke, Mr. Cranston, Mr. Beall, Mr. Cannon, Mr. Case, Mr. Eagleton, Mr. Gurney, Mr. Harris, Mr. Hart, Mr. Hollings, Mr. Hughes, Mr. Humphrey, Mr. McGee, Mr. McGovern, Mr. Mondale, Mr. Moss, Mr. Nelson, Mr. Pastore, Mr. Percy, Mr. Randolph, Mr. Ribicoff, Mr. Stafford, Mr. Stevens, Mr. Stevenson, Mr. Taft, Mr. Tower, Mr. Tunney, and Mr. Young) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act so as to provide for the prevention and control of venereal disease.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 SHORT TITLE
4 Section 1. This Act may be cited as the "National
5 Venereal Disease Prevention and Control Act".
6 FINDINGS AND DECLARATION OF PURPOSE
7 Sec. 2. (a) The Congress finds and declares that—
8 (1) the number of reported cases of venereal dis-
9 ease has reached epidemic proportions in the United
10 States;

1 (2) the number of patients with venereal disease
2 reported to public health authorities is only a fraction
3 of those treated by physicians;
4 (3) the incidence of venereal disease is particu-
5 larly high among individuals in the 20–24 age group,
6 and in metropolitan areas;
7 (4) venereal disease accounts for needless deaths
8 and leads to such severe disabilities as sterility, insanity,
9 blindness, and crippling conditions;
10 (5) the number of cases of congenital syphilis,
11 a preventable disease, in infants under one year of age
12 increased by $33\frac{1}{3}$ per centum between 1970 and 1971;
13 (6) health education programs in schools and
14 through the mass media may prevent a substantial por-
15 tion of the venereal disease problem; and
16 (7) medical authorities have no successful vac-
17 cine for syphilis or gonorrhea and no blood test for the
18 detection of gonorrhea among the large reservoir of
19 asymptomatic females.
20 (b) In order to preserve and protect the health and
21 welfare of all citizens, it is the purpose of this Act to estab-
22 lish a national program for the prevention and control of
23 venereal disease.

1 AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

2 SEC. 3. (a) Part B of title III of the Public Health
3 Service Act is amended by adding immediately after section
4 317 thereof the following new section:

5 "PROJECTS AND PROGRAMS FOR THE PREVENTION
6 AND CONTROL OF VENEREAL DISEASE

7 "SEC. 318. (a) The Secretary is authorized to conduct,
8 and render assistance to appropriate public authorities and
9 scientific institutions in the conduct of research, training,
10 and public health programs relating to the prevention and
11 control of venereal disease.

12 "(b) (1) The Secretary is authorized to make grants
13 to States, political subdivisions, universities, hospitals, and
14 other public or nonprofit private institutions, agencies, insti-
15 tutions, or organizations, for projects for the conduct of re-
16 search, demonstrations, or training for the prevention or
17 control of venereal disease.

18 "(2) For the purpose of carrying out this subsection,
19 there is authorized to be appropriated the sum of $15,-
20 000,000 for the fiscal year ending June 30, 1973, and for
21 each of the next two succeeding fiscal years.

22 "(c) (1) There is authorized to be appropriated the
23 sum of $25,000,000 for the fiscal year ending June 30,
24 1973, and for each of the next two succeeding fiscal years,

1 to enable the Secretary to make grants to State health au-
2 thorities to assist the States in establishing and maintaining
3 adequate public health programs for the diagnosis and treat-
4 ment of venereal disease. The sums so appropriated shall be
5 used for making payments to States which have submitted,
6 and had approved by the Secretary, State plans for the pro-
7 vision of public health services for the diagnosis and treat-
8 ment of venereal disease.
9 "(2) In order to be approved under this subsection, a
10 State plan for the provision of public health services for the
11 diagnosis and treatment of venereal disease must—
12 "(A) provide for the administration or supervision
13 of administration by the State health authority;
14 "(B) set forth the policies and procedures to be
15 followed in the expenditure of the funds paid to the
16 State under this subsection;
17 "(C) provide that the public health services fur-
18 nished under the plan will include the provision of State-
19 wide laboratory services which include Darkfield micro-
20 scopes for the diagnosis of both gonorrhea and syphilis,
21 and will otherwise be in accordance with standards pre-
22 scribed by regulations, including standards as to the scope
23 and quality of such services;
24 "(D) contain or be supported by assurances satis-
25 factory to the Secretary that (i) the funds paid to the

1 State under this subsection will be used to make a sig-
2 nificant contribution toward providing and strengthen-
3 ing public health services for the diagnosis and treat-
4 ment of venereal disease in the various political subdivi-
5 sions in order to improve the health of the people; (ii)
6 such funds will be used to supplement and, to the extent
7 practical, to increase the level of funds that would other-
8 wise be made available for the purposes for which the
9 Federal funds are provided and not to supplant any non-
10 Federal funds which would otherwise be available for
11 such purpose; and (iii) the plan is compatible with the
12 total health program of the State;
13 "(E) provide that the State health authority will
14 from time to time, but not less often than annually, re-
15 view and evaluate its State plan approved under this
16 subsection, and submit to the Secretary appropriate
17 modifications thereof;
18 "(F) provide that the State health authority will
19 make such reports, in such form and containing such in-
20 formation, as the Secretary may from time to time
21 reasonably require, and will keep such records and afford
22 such access thereto as the Secretary finds necessary to
23 assure the correctness and verification of such reports;
24 "(G) provide for such fiscal control and fund ac-
25 counting procedures as may be necessary to assure the

1 proper disbursement of and accounting for funds paid to
2 the State under this subsection; and
3 "(H) contain such additional information and assur-
4 ances as the Secretary may find necessary to carry out
5 the purposes of this subsection.
6 "(3) From the sums appropriated to carry out the pro-
7 visions of this subsection, the several States shall be entitled
8 for each fiscal year to allotments determined, in accordance
9 with regulations, on the basis of the incidence of venereal
10 disease in, and the population of, the respective States; ex-
11 cept that no State's allotment shall be less than $50,000 for
12 any fiscal year.
13 "(4)(A) From each State's allotment under this sub-
14 section for a fiscal year, the State shall be paid a Federal
15 share of the expenditures incurred during such year under its
16 State plan approved under this subsection. Such payments
17 shall be made from time to time in advance on the basis of
18 estimates by the Secretary or by way of reimbursement,
19 with necessary adjustments on account of previous under-
20 payments or overpayments.
21 "(B) The Federal share for any State shall be such
22 per centum (not in excess of 90 per centum) of the expendi-
23 tures of such State (referred to in subparagraph (A)) as
24 shall be established by such State.

1 "(C) 'State' means each of the several States of the
2 United States, the District of Columbia, the Virgin Islands,
3 Guam, American Samoa, Trust Territory of the Pacific
4 Islands, and the Commonwealth of Puerto Rico.
5 "(D) Any amount so allotted to a State during any such
6 fiscal year (other than the Virgin Islands, American Samoa,
7 Guam, the Trust Territory of the Pacific Islands, and the
8 Commonwealth of Puerto Rico) and remaining unobligated
9 at the end of such year shall remain available to such State,
10 for the purposes for which made, for the next fiscal year
11 (and for such year only) and any such amount shall be in
12 addition to the amounts allotted to such State for such pur-
13 pose for such next fiscal year; except that any such amount
14 remaining unobligated at the end of the sixth month follow-
15 ing the end of such year for which it was allotted which
16 the Secretary determines will remain unobligated by the
17 close of such next fiscal year may be reallotted by the Secre-
18 tary, to be available for the purposes for which made until
19 the close of such next fiscal year, to other States which have
20 need therefor, on such basis as the Secretary deems equitable
21 and consistent with the purposes of this subsection, and any
22 amount so reallotted to a State shall be in addition to the
23 amounts allotted and available to the States for the same
24 period. Any amount allotted under this subsection of this
25 section to the Virgin Islands, American Samoa, Guam, the

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1 Trust Territory of the Pacific Islands, or the Commonwealth
2 of Puerto Rico for a fiscal year and remaining unobligated
3 at the end of such year shall remain available to it for the
4 purposes for which made, for the next two fiscal years (and
5 for such years only), and any such amount shall be in addi-
6 tion to the amounts allotted to it for such purpose for each of
7 such next two fiscal years; except that any such amount, re-
8 maining unobligated at the end of the first of such next two
9 years, which the Secretary determines will remain unobli-
10 gated at the close of the second of such next two years,
11 may be reallotted by the Secretary, to be available for the
12 purposes for which made until the close of the second of
13 such next two years, to any other of such named States which
14 have need thereto, on such basis as the Secretary deems
15 equitable and consistent with the purposes of this part, and
16 any amount so reallotted to any such named State shall be
17 in addition to any other amounts allotted and available to it
18 for the same period.
19 "(d) (1) The Secretary is authorized to make project
20 grants to States and, with the approval of the State health
21 authority, to political subdivisions of States, for the conduct
22 of venereal disease prevention and control programs.
23 "(2) For purposes of this subsection, the term 'vene-
24 real disease prevention and control program' means a pro-
25 gram which includes—

1 "(A) disease surveillance activities, including the
2 reporting, screening, and followup of diagnostic tests
3 and diagnosed cases of venereal disease;
4 "(B) casefinding and case followup activities,
5 including contact tracing of infectious cases;
6 "(C) interstate epidemiologic referral and follow-
7 up activities;
8 "(D) professional and public venereal disease edu-
9 cation activities; and
10 "(E) such special studies or demonstrations to
11 evaluate or test venereal disease control as may be pre-
12 scribed by the Secretary.
13 "(e) Grants made under subsection (b) or (d) of
14 this section shall be made on such terms and conditions as
15 the Secretary finds necessary to carry out the purposes of
16 such subsection, and payments under any such grants shall
17 be made in advance or by way of reimbursement and in such
18 installments as the Secretary finds necessary.
19 "(f) Nothing in this section shall be construed to limit
20 or otherwise restrict the use or availability of funds which
21 are granted to a State or to a political subdivision of a State
22 under other provisions of this Act or any other Federal law
23 and which are available for the conduct of venereal disease
24 programs from being used in connection with programs as-
25 sisted through grants under this section.

1 "(g) For the purpose of carrying out this subsection,
2 there is authorized to be appropriated the sum of $30,000,-
3 000 for the fiscal year ending June 30, 1973, and for each
4 of the next two succeeding fiscal years.

5 "(h) Each recipient of assistance under this section
6 shall keep such records as the Secretary shall prescribe, in-
7 cluding records which fully disclose the amount and disposi-
8 tion by such recipient of the proceeds of such assistance, the
9 total cost of the project or undertaking in connection with
10 which such assistance is given or used, and the amount of
11 that portion of the cost of the project or undertaking sup-
12 plied by other sources, and such other records as will facili-
13 tate an effective audit.

14 "(i) The Secretary and the Comptroller General of the
15 United States, or any of their duly authorized representa-
16 tives, shall have access for the purpose of audit and examina-
17 tion to any books, documents, papers, and records of the re-
18 cipients that are pertinent to the assistance received under
19 this section.

20 "(j) The Secretary, at the request of a recipient of a
21 grant under this section, may reduce such grant by the fair
22 market value of any supplies, or equipment furnished to such
23 recipient and by the amount of pay, allowances, traveling
24 expenses, and any other costs in connection with the detail
25 of an officer or employee to the recipient when the furnish-

1 ing of such supplies or equipment, or the detail of such officer
2 or employee (as the case may be), is for the convenience of
3 and at the request of such recipient and for the purpose of
4 carrying out the program with respect to which the grant
5 under this section is made. The amount by which any such
6 grant is so reduced shall be available for payment by the
7 Secretary of the costs incurred in furnishing the supplies,
8 equipment, or personal services on which the reduction of
9 such grant is based, but such amount shall be deemed a part
10 of the grant to such recipient and shall, for the purposes of
11 this section, be deemed to have been paid to such agency."
12 (b) Section 314 (d) (2) of the Public Health Service
13 Act is amended—
14 (1) by striking out ", and" at the end of clause
15 (K) and inserting in lieu thereof ";";
16 (2) by striking out the period at the end of clause
17 (L) and inserting in lieu of such period "; and"; and
18 (3) adding after clause (L) the following new
19 clause:
20 "(M) effective July 1, 1973, provide for services
21 for the prevention and control of venereal disease.".

Senator KENNEDY. I want to welcome the Administration witnesses, Dr. DuVal, Assistant Secretary for Health and Scientific Affairs, accompanied by John S. Zapp, Deputy Assistant Secretary for Legislation, Mr. Robert J. Laur, Deputy Administrator for Prevention and Consumer Services of the Health Services and Mental Health Administration, and Dr. David J. Sencer, Director of the Center for Disease Control, Health Services and Mental Health Administration.

STATEMENT OF DR. MERLIN K. DUVAL, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, HEW; ACCOMPANIED BY JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), HEW; ROBERT J. LAUR, PH. D., DEPUTY ADMINISTRATOR FOR PREVENTION AND CONSUMER SERVICES, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, HEW; AND DAVID J. SENCER, M.D., DIRECTOR, CENTER FOR DISEASE CONTROL, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, HEW

Dr. DUVAL. Thank you, Mr. Chairman. This is Dr. Laur's first appearance before your committee and we are pleased to have him with us this morning.

I am glad 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 the present 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 disease.

In fact, new developed vaccines, drugs, and improved methodologies make it possible to project realistically not just the cure but the eradication of many historical 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 worldwide smallpox eradication program, of which the United States 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.

We must, Mr. Chairman, remain free to evaluate and reevaluate objectively the status of diseases, levels of protection, and current state of scientific and technological development, if we are to continue to provide leadership in improving the health protection of the people of this country, and by necessary implications of the world.

You expect this of us, and it is our willing responsibility; yet the constraints of fear, misconception and prior knowledge must be ac-

cepted. New facts and redefined methodologies require both improved communications and usable statutory authorities.

When, as in the case of smallpox, we need to redirect our approach and, for example, make known the reduced risk of infection vis-a-vis the potential for reactions to inoculation, we need to be able to accomplish this task under available authorities as well as to be able to respond to the impact this redirection makes upon State and local resources.

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.

S. 3442 would extend the 1970 Communicable Disease Amendments by providing in section 317 of the Public Health Service Act an appropriations ceiling of $90 million for fiscal year 1973 and each of the next 4 fiscal years. Aside from minor changes in wording, the only other substantive change provided in the bill is the addition of a new subsection, 317(h), authorizing the appropriation of up to $5 million for each of the next fiscal years (5) for the purpose of supporting grants or contracts with public and private nonprofit agencies to carry out public awareness programs.

Beyond the problems of redirecting at State and local levels categorical emphasis established by legislation, as I have discussed, the addition of the subsection authorizing a public awareness, or health education program would create further redundancy and complexity in our legislative authorities in the health field.

Similar international and publication distribution authority can be found and is now being utilized under section 301 of the PHS Act, as well as sections 311, 314, and 315.

In addition, the committee is considering S. 3187—"National Venereal Disease Prevention and Control Act"—which would authorize during fiscal years 1973 through 1975 a multiphase venereal disease control program. For each fiscal year there would be authorized an appropriation ceiling of $70 million which would be used as follows: $15 million for project grants to public or private nonprofit organizations to carry out research, demonstrations, or training for the prevention or control of venereal disease; $25 million for formula grants to States for venereal disease diagnostic and treatment services; and $30 million for project grants to States for carrying out venereal disease prevention and control programs.

Again, let me emphasize that the Public Health Service Act now contains authority for these kinds of programs. In section 301 there is ample authority for research and demonstrations and in section 314 there is formula grant and project grant authority which would serve the same purposes as provided for in S. 3187.

Present authorities, as cited, I think offer ample support for the support of ongoing activities in these activities in which we are all so 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.

Number of cases of paralytic polio:	
1962	910
1971	12

Looking back over the 10 years 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. However, when it was found that there were pockets of nonimmunized children, it was possible to respond rapidly to this need by reprograming funds under 314(e) and 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 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 the 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):

Number of cases reported:	
1962	481, 530
1971	75, 007

Since measles is a very highly infectious communicable disease, a slight fall off 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 marked serious, heartbreaking, consequences, not to the person with the disease but rather to the unborn children.

Pregnant women who contracted rubella during the first trimester of their pregnancy can and do run the terible 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 all 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 efforts 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; and (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.

Under the circumstances, the number of reported cases fell from 1962 from 53,315 to 37,137 in 1970.

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 annual rate of decline of new active cases had 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 all-time 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 program 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 upward. Additionally, there are 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 the 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, such that in 1962 there were 20,084 cases, in 1969, 18,679 cases, and in 1971, 23,336 cases.

The 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 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 years. During this decade the disease trend has looked like this:

Reported gonorrhea:	
1962	260, 468
1971	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. 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.

In the laboratory, an effective diagnostic technique was developed and tested which now makes it possible to overcome a major obstacle and to the control of gonorrhea—the inability to detect the disease in infectious, but asymptomatic females.

It was not possible to recommend for the first time that effective public health programs for the control of gonorrhea would be undertaken. For fiscal year 1973, the President has requested a total of $24.8 million in project grant funds for a national venereal disease program that 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 are requesting that the Congress raise the authorization ceiling for section 314(e) to permit us to carry out these activities. This action 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 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 for 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 the State formula and categorial thrust of section 317.

Accordingly, we recommend against enactment of S. 3187 and S. 3442. Instead, we strongly recommend that you further improve the comprehensive health partnership legislation by increasing the authorization ceilings to permit us to take advantage of improvement opportunities as they arise. Draft legislation to accomplish this ob-

jective is being submitted to the Congress by the Department of Health, Education, and Welfare.

Senator KENNEDY. Thank you very much, Dr. DuVal. We have some fundamental points of departure or disagreement which we all recognize, but certainly the point on which we agree is the necessity to get about the business of doing something about communicable diseases. We differ, and obviously both the administration and this subcommittee have strong views as to the best way of achieving control of these diseases.

I am wondering perhaps at the start if Dr. Sencer could give us some idea of what progress is being made in the area of communicable disease. What has been happening in the last year or two? I am interested just in terms of finding out where we are on some of them; what kind of hope is there, really, for the future; what we are getting a handle on and what areas are getting away from us.

We are going to hear later from the Commission on Venereal Diseases, so you might touch on that, but I would be interested in what is happening in the other areas and what can you tell us for the mothers of the country in terms of their children?

Dr. SENCER. I think that we can describe quite fine progress in many of the communicable diseases, Mr. Chairman.

This past year there were only 12 cases of paralytic polio in the entire United States, which I think was a remarkable achievement. Diphtheria was down to 50 percent, only 203 cases, and tetanus continues at a low level. There are only 121 cases of tetanus reported in the United States.

As Dr. DuVal mentioned in his testimony, over 70 percent of the children in school have been vaccinated against rubella, and almost 50 percent of the pre-school children in the United States, about 47 percent, have been immunized. If we had been testifying a year ago——

Senator KENNEDY. What is really the problem in terms of the 50 percent?

Dr. SENCER. The first 2 years we concentrated on the school-age child, the child we thought was the spreader. This past year there has been more attention being paid to the pre-school child, and I think this is the way we anticipated things going.

We have had a few areas in the country where there has been some reluctance about the use of the vaccine. Most parts of the country now agree with the approach being used.

Senator KENNEDY. What is your target over the period of the next 3 years? What percent of the pre-school children do you expect to have vaccinated by that time?

Dr. SENCER. By the end of next fiscal year, we expect about 44 or 45 million children to have been vaccinated in community programs. This will leave probably only about 8 million children as susceptibles in the country, so we should be reaching around 75 percent of all children within the next year.

Senator KENNEDY. These are all pre-school?

Dr. SENCER. No, these are total, of the total susceptible population. We estimate there are around 55 million children, pre-pubertal children, who need immunization. We have reached 35 million at the present time. By next year we hope to have immunized 45 million.

Senator KENNEDY. What could you tell us in terms of the groups in our society that are missing out on the vaccination? Is it related to either social or economic conditions?

Dr. SENCER. The groups that are missing out on immunization are groups that have had difficulty in achieving access to our health care system. If we look at immunization levels in the central cities, the preschool children have the lowest levels of immunization against all the diseases. This is why our strategy has been aimed at groups such as Headstart, daycare centers and so on, trying to reach into the central cities to the disadvantaged groups and bring the immunization to them as conveniently as possible.

Senator KENNEDY. What about groups like migrant workers? Do you have any figures on that?

Dr. SENCER. This is hard to get, a large-scale picture, but in some work we have been doing in Florida and in the Texas migrant stream, they are at a lower level, and recognizing this we are gearing programs to reach toward congregations of migrants in Texas.

We are working in the lower valley where most of them come for the winter. In Florida, in conjunction with our public health programs in nutrition, we are including immunization.

Senator KENNEDY. The Indians, do they get pretty good coverage through public health?

Dr. SENCER. I wish I could say they receive excellent immunization, but they have the highest rates of diphtheria in the country. Where you have a scattered population, it is difficult to maintain high levels of immunization. Dr. DuVal is more familiar with this than I am, but the cultural problems of accepting something when you are well is a hard one to overcome.

Senator KENNEDY. Is that it as far as the diseases themselves?

I think you covered the diphtheria reaction and rubella and polio.

Dr. SENCER. I was going to say, Mr. Chairman, that if we had testified last year we would have been embarrassed about the situation in measles. Last year measles reached the highest levels since 1966. However, this year we have brought about a considerable reduction and it is back down in levels of 1965 and 1966. In the fall and winter, those months of last year, there were about 77,000 reported cases of measles and there are only about 40,000 in a similar period this year.

This again was brought about by the fact that we had not been making funds available for the purchase of measles vaccine.

Senator KENNEDY. Just in terms of trying to develop programs in these different areas, does it really make a difference whether it comes under an administrative point of view or an organizational point of view?

In other words, from an administrative point of view, would knowing what funds you are going to receive and being able to target those funds provide a greater degree of administrative efficiency?

Dr. SENCER. As Dr. DuVal pointed out, all the progress we have made in the last 5 years has been under 314(e) authority. Until this year, we have had practically no funds appropriated under 317 authority but the mechanism of awarding grants and so on is the same under 314 as it would be under 317.

Senator KENNEDY. In terms of getting funds under 314 for the various programs, could you explain to us how you are able to get funds?

Dr. SENCER. Actually this is involved in the budget process. Since 314(e) funds have been available, each year funds have been earmarked, if you will, for venereal diseases, rubella, polio, or other diseases. We have developed this in our normal budgeting cycle, and until this year, when we are having a ceiling authority problem, there has been no difficulty in our getting the funds that have been requested.

Senator KENNEDY. Could you tell us a little bit about how you regard the venereal disease epidemic and really how you are trying to respond to it?

Dr. SENCER. Yes. I think the response is evident, looking at the budget. The President in his health message mentioned that a total of $31 million is being requested for venereal disease control. This is an increase of almost 2½ times what it was 2 years ago. This coming year there will be close to $25 million available for grants to local health departments to develop control programs, to pick up where we have lost out in syphilis, and try to begin to stem the tide of gonorrhea. I think we anticipate, even though we are going to be devoting more funds, an increase in gonorrhea in the coming year, because if we begin to look more strenuously we are going to find more cases.

The strategy is aimed at, principally, trying to identify the large reservoir of people who do not know they have venereal disease and bring them under treatment. There is going to be an educational program reaching into the schools and into the communities to bring about an awareness to the problems of venereal disease.

Senator KENNEDY. Senator Javits has a question. You relied upon sections 301 and 314 for funding VD programs; could you supply a dollar-by-dollar breakdown under those authorities which have been budgeted for treatment and diagnosis of VD?

Dr. SENCER. Yes; in 1973 we have requested $6.2 million under the first section and $24.8 million under 314.

Senator KENNEDY. Could you provide how that is broken down within those sections, too?

Dr. SENCER. Yes, sir.

Senator KENNEDY. Perhaps you could give a breakdown in the other diseases, too? I would be interested in seeing how that money goes from the Department out into the areas, through 1971.

Dr. SENCER. Out into the areas, the States?

Yes, sir; we will provide that.

(The information referred to follows:)

FUNDING OF VENEREAL DISEASE PROGRAMS BY AUTHORITY

		1972	1973
Direct Operations:	Sections 301, 308, 311, 315, 361 --	$6,044,000	$6,251,000
Research Grants:	Sections 301 and 308 ---	166,000	255,000
Project Grants:	Section 314(e) and 317		

State	1972 314 e Estimate	1972 317 Estimate	1972 Total Estimate	1973 314 e Estimate
Alabama	$187,275	$367,059	$554,334	$582,443
Alaska	-	52,522	52,522	60,763
Arizona	60,555	238,993	299,548	336,765
Arkansas	29,865	152,482	182,347	210,969
California	566,499	1,516,365	2,082,864	2,314,913
Colorado	16,170	183,776	199,946	227,810
Connecticut	34,650	112,863	147,513	165,093
Delaware	14,850	55,270	70,120	80,389
Dist. of Col.	168,795	225,414	394,209	423,629
Florida	455,565	691,496	1,147,061	1,225,865
Georgia	246,510	486,492	733,002	819,731
Hawaii	-	115,983	115,983	134,166
Idaho	-	49,333	49,333	57,089
Illinois	393,690	723,713	1,117,403	1,221,513
Indiana	77,220	258,527	335,747	386,708
Iowa	11,550	170,465	182,015	207,321
Kansas	13,695	162,826	176,521	203,125
Kentucky	36,960	209,842	246,802	277,398
Louisiana	177,705	312,431	490,136	536,351
Maine	-	62,756	62,756	72,452
Maryland	168,465	263,196	431,661	461,848
Massachusetts	81,510	217,577	299,087	331,354
Michigan	308,880	483,641	792,521	844,380
Minnesota	14,190	250,245	264,435	304,900
Mississippi	93,060	236,318	329,378	357,661
Missouri	53,130	395,653	448,783	512,485
Montana	-	55,363	55,363	64,089
Nebraska	13,530	141,371	154,901	176,044
Nevada	9,405	51,661	61,066	71,881
New Hampshire	-	47,977	47,977	55,490
New Jersey	174,405	335,770	510,175	565,365
New Mexico	47,190	144,477	191,667	215,719
New York	945,205	1,03[illegible],199	2,029,[illegible]	2,161,719
North Carolina	181,995	359,128	541,123	587,025
North Dakota	-	49,416	49,416	57,172

Project Grants: Venereal Disease (cont'd)

State	1972 314 e Estimate	1972 317 Estimate	1972 Total Estimate	1973 314 e Estimate
Ohio	$224,400	$816,102	$1,040,502	$1,161,515
Oklahoma	31,020	272,311	303,331	344,911
Oregon	14,271	177,018	191,289	215,426
Pennsylvania	127,050	513,830	640,880	711,851
Rhode Island	12,870	123,809	136,679	158,240
South Carolina	184,140	215,972	400,112	420,977
South Dakota	10,890	55,782	66,672	74,305
Tennessee	75,240	403,425	478,665	536,602
Texas	609,015	1,178,493	1,787,508	1,980,630
Utah	-	48,377	48,377	55,890
Vermont	-	44,729	44,729	51,757
Virginia	76,395	374,572	450,967	506,051
Washington	14,850	201,395	216,245	248,242
West Virginia	13,200	89,318	102,518	114,825
Wisconsin	20,295	191,456	211,751	242,037
Wyoming	-	41,403	41,403	47,946
Puerto Rico	261,855	367,575	629,430	672,877
Virgin Islands	41,910	43,833	85,743	89,030
American Samoa	-	32,000	32,000	37,088
Guam	-	32,000	32,000	37,088
Trust Territory	-	32,000	32,000	37,087
Reserve	-	480,000	480,000	744,000
Total	$6,300,000	$16,000,000	$22,300,000	24,800,000

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FUNDING OF IMMUNIZATION AND TUBERCULOSIS PROGRAMS BY AUTHORITY

Direct Operations: Sections 301, 308, 311, 315, 361

	1972	1973
Immunization	$1,061,000	$1,080,000
Tuberculosis	3,908,000	4,043,000

Research Grants: Sections 301 and 308

	1972	1973
Immunization	566,000	590,000

Project Grants: Sections 314(e) and 317

Immunization

State	1972 314e Estimate	1972 317 Estimate	1972 Total Estimate	1973 314(e) Estimate
Alabama	$350,313	$ 17,000	$367,313	$281,300
Alaska	67,775	42,000	109,775	96,200
Arizona	151,065	63,000	214,065	175,800
Arkansas	158,667	44,000	202,667	170,000
California	1,532,120	65,000	1,597,120	1,290,700
Colorado	160,589	55,000	215,589	171,500
Connecticut	116,227	97,000	213,227	190,000
Delaware	66,595	38,000	104,595	83,300
Dist. of Columbia	166,017	50,000	216,017	162,800
Florida	395,505	169,100	564,605	485,500
Georgia	248,853	124,700	373,553	323,800
Hawaii	86,756	17,000	103,756	86,400
Idaho	99,982	17,000	116,982	89,000
Illinois	634,921	175,000	809,921	678,000
Indiana	198,246	59,100	257,346	201,700
Iowa	175,140	27,000	202,140	167,100
Kansas	162,798	27,000	189,798	157,200
Kentucky	223,880	22,000	245,880	201,100
Louisiana	289,008	85,000	374,008	300,200
Maine	81,715	42,000	123,715	107,400
Maryland	236,831	107,400	344,231	280,900
Massachusetts	289,310	42,000	331,310	273,400
Michigan	369,123	305,000	674,123	600,400
Minnesota	264,543	32,000	296,543	243,600
Mississippi	254,558	17,000	271,558	214,600

Project Grants: Immunization (contd.)

State	1972 314e Estimate	1972 317 Estimate	1972 Total Estimate	1973 314(e) Estimate
Missouri	377,103	209,600	586,703	491,300
Montana	74,293	32,000	106,293	91,400
Nebraska	114,011	55,000	169,011	146,200
Nevada	67,488	51,000	118,488	97,000
New Hampshire	53,162	42,000	95,162	72,500
New Jersey	234,566	129,000	363,566	316,600
New Mexico	106,277	38,000	144,277	115,000
New York	788,175	260,000	1,048,175	890,600
North Carolina	326,945	80,000	406,945	341,600
North Dakota	55,301	42,000	97,301	82,200
Ohio	$357,533	$110,000	$467,533	396,000
Oklahoma	177,266	42,000	219,266	171,800
Oregon	121,215	100,800	222,015	181,800
Pennsylvania	666,560	114,000	780,560	615,300
Rhode Island	69,844	42,000	111,844	97,900
South Carolina	220,088	17,000	237,088	193,100
South Dakota	82,571	42,000	124,571	104,100
Tennessee	425,212	26,000	451,212	360,200
Texas	757,844	177,000	934,844	755,200
Utah	82,710	32,000	114,710	90,200
Vermont	67,873	42,000	109,873	84,300
Virginia	245,883	37,000	282,883	227,700
Washington	83,500	169,700	253,200	216,500
West Virginia	176,165	27,000	203,165	167,900
Wisconsin	191,723	69,600	261,323	223,000
Wyoming	47,784	27,000	74,784	59,200
Puerto Rico	199,821	95,000	294,821	254,800
Virgin Islands	48,550	32,000	80,550	62,800
American Samoa	---	---	---	25,000
Guam	---	---	---	45,000
Trust Territory	---	---	---	56,000
Reserve	---	120,000	120,000	435,000
TOTALS	13,000,000	4,000,000	17,000,000	14,500,000

Senator KENNEDY. Dr. Sencer, you mentioned here that as you begin to sort of target the funds and increase funds on venereal disease, you will begin to find more around the country. How much of an impact can you make on this with the funds that have been requested and actually appropriated this year?

You have mentioned in terms of polio, diphtheria, tetanus, and rubella, how effective that has been. What kind of a job can you do?

Dr. SENCER. I think we will see a decrease in infectious syphilis this year—a 15- to 20-percent decrease. We will see an increase, however, in gonorrhea in the coming year. I think the impact, though, will be on the number of people that receive attention.

We anticipate screening over 2 million people this coming year for gonorrhea, and we will find a fair percentage of these people brought to treatment, and thus we will be preventing cases of gonorrhea. The things that don't show in statistics of this nature are the number of cases of the disease which are prevented.

We are anticipating that we will prevent about 150,000 cases the first year. That is not much in comparison to 2 million cases, but we think within a year and a half to 2 years we will see the gonorrhea curve turn downward.

Senator KENNEDY. How much of it is related to the amount of money that is available? How much is in terms of administration? Could you use more money effectively?

Dr. SENCER. The funds we are receiving this year and what we were provided last year was our best professional estimate of what was necessary to do the job. The budget for 1973 shows an increase, again, in our venereal disease funds.

Senator KENNEDY. Dr. DuVal, we have seen from our vantage point that the administration has supported the targeting of different programs in the fields of cancer and heart, and more recently in terms of sickle cell anemia.

Now, why shouldn't we target a program for venereal disease, given the recommendations of an enormously gifted and talented panel of experts outlining one of the most serious kinds of health problems?

Dr. DUVAL. Mr. Chairman, I would submit our approach with regard to targeting on the other disease is consistent. The principle of the administration is to try to do everything it can to make the Department of Health, Education, and Welfare a viable, effective, and responsive department, which means keeping down the reduplication of unnecessary authorities.

The sickle cell problem, as you know, has been handled within the existing heart and lung institute authorities. In appearances before this committee I have urged that the heart problems and others be kept within their appropriate existing authorities, and we asked, specifically, that the cystic fibrosis provision of the chairman's heart bill be treated under the existing authority that rests with the National Institutes of Arthritis and Metabolic Diseases.

So our approach would be to attempt to avoid the continuing duplication of authorities within the Department, duplication in the sense that each of these authorities permits us to do the same thing.

Each time we get a new one we have to start with legal clearances, guidelines, and so forth, setting up a new bureaucracy for each authority. I hope our position has been consistent.

Senator KENNEDY. As I understand the Javits approach, it is keeping it within the communicable disease program, as we kept the heart program within the NIH.

They are not going way outside the authority. As I understand it, they are targeting in on communicable disease. But in sharing this responsibility with the administration, we want to reflect the congressional sense of priority about it, rather than leaving it as a floating question, albeit the good intentions of the administration, as to how they are going to divide up the pie between the various programs.

Dr. DUVAL. I believe our record is consistent since the passage of the Partnership in Health Act. The ideal way to be responsive to the needs of the community, we think, is to take advantage of the combined provisions of 314(d) and 314(e). We can target, and at the same time leave certain money in the hands of the administrative officials in the States, so that each State can meet its own problems.

With a single authority such as 314, we are able to accomplish all of the objectives that others would accomplish by adding new authorities that don't give us anything but additional pieces of bureaucracy.

Senator KENNEDY. I suppose the real question is whether you are dividing that pie up so thin in the sense of health centers, rat control, and communicable diseases that you might not get the job done. As one who offered an amendment in terms of the Neighborhood Health Corps, I remember that we introduced at that time amendments to the OEO program and put them on a permanent basis. Then it was moved over to the comprehensive health centers under 314(e), and that, as I understod, was supposed to be the purpose and the thrust of the legislation.

Now it has been spread out to include all these other factors; and as a result there is a real question, certainly in our minds, about how effective all of these programs are going to be.

Dr. DUVAL. I would be delighted to relieve the chairman of any concern that we would not be responsible or responsive even if the programs were spread out thin in 314 (d) and (e). I would submit that this year we believe 314(e) has been spread too thin and we are coming back with a specific request that the authorization in 314(e) be increased.

There is testimony to the fact that we do not wish to spread the resources too thin over 314(e).

Senator KENNEDY. What is the request? You are mentioning 314(e). How much budget request is for that?

Give me (d) first. You have $165 million authorized.

Dr. DUVAL. I think we will have to supply that for the record. None of us know this year's request for 314(d), Mr. Chairman. For 314(e) I think it is $179 million.

(The information referred to follows:)

[In thousands of dollars]

	PHS Act 314(d)	PHS Act 314(e)
Current authorization—1973	165,000	157,000
Increase for 1973 proposed by H.R. 14341	0	22,000

Dr. DUVAL. The authorization is $157 million. We are asking it be increased.

Senator KENNEDY. Section 314(d) is the formula grant.

Dr. DuVal. Yes.

Senator Kennedy. That entitles all the States to a certain amount.

Dr. DuVal. That is correct. I think it is $90 million. I am quite sure it is $90 million.

Senator Kennedy. That is the figure we have got. How does that work in terms of something like TB, which can be targeted as a particular problem, if you have a formula grant and have to distribute a certain amount to other programs. How effective is the use of funds through that particular device?

Dr. Sencer. The way the formula is structured at the present time, it does not necessarily reflect the extent of the problem of the diseases not evenly distributed throughout the country. Diseases such as mental disease, heart disease and cancer are quite evenly distributed across the country, and therefore a capitation approach flavored a little by the per capita income of the State does make it equal.

But the capitation formula is not adequate for venereal diseases as a means of distributing money.

Senator Kennedy. Couldn't you target a program more effectively or, as a health expert, couldn't you get more effective utilization of funds if you could pinpoint it?

Dr. Sencer. In the project grant authority in the past we have been able to do that better, yes, sir.

Dr. DuVal. I might add we can still do the same thing under 314. As a supplement to what the States get under (d), and his answer, of course, is not consistent with that.

Senator Kennedy. Could you give us at least some idea what goes out under (d) and (e) in these programs so we get some idea, on a State by State basis? Could you do that for us?

Dr. Sencer. We can do that for (e) easily.

Senator Kennedy. What about (d)?

Dr. Sencer. We can give you the State allocations, but not necessarily what it is used for. The reporting system is such that we don't have that information.

Senator Kennedy. Could you give me that again?

Dr. Sencer. Under (d), 15 percent by law goes for mental health, 70 percent of the funds that are available to the States have to be used for community services. They cannot be used for a central office type of activity. Beyond that, we have relatively poor information on specific disease categories.

The title of this is "Comprehensive Health Services," and it is very difficult to say what part of a public health nurse is being devoted to tuberculosis and so forth. So it is not kept in that way.

Senator Kennedy. It is hard to tell how much of that money is really being charged to any particular disease?

Dr. Sencer. At the present time, the community health services has a contract with the State health officers to try to develop a uniform reporting system for the State health departments for the use of their Federal funds.

I have not seen the reports as yet, but they are working on this for venereal disease and rubella among other things.

Senator Kennedy. When will that report be available?

Dr. Sencer. I don't know.

Dr. DuVal. I believe it is the second year of a 3-year contract. We are at the end of a second year now, Mr. Chairman. The issue has been well explained by Dr. Sencer. The answer to the question you are asking is there, not here. That is, it resides in each health department. Each of the 50 State jurisdictions may keep its books differently, so it is difficult to draw a specific answer with regard to one disease.

I might add that is one reason we hope to have a flexibility as in 314(e), so that we can correct faults in the distribution.

Senator Kennedy. I suppose one of the problems in (d) is leaving it completely up to the States on the question of communicable disease, so Massachusetts might decide one way and New Hampshire another; and although disease transfer knows no State boundary, when you have different approaches on different diseases, you wonder how effective a more consolidated approach would be. There are serious questions as to whether that is the most effective way of distribution of the funds to do the job.

I guess we don't know that until we get the results of the report or study.

Dr. DuVal. If I could suggest, Mr. Chairman, we agree with you completely. This is the defect at the moment in the 314(d) program, but as I have already indicated, we can accommodate to that with 314(e), but without the extra regulations and the bureaucracy.

Senator Kennedy. Can you tell us, is the position of the OMB that this is a more efficient way in terms of allocating these funds? What can you tell us about that?

Dr. DuVal. I think it is the posture of the administration as a whole that it is best to enjoy the opportunities of both formula and project capability in the administration with the least irreducible number of authorities necessary to achieve the objective.

The point I am making is that each time you add a new authority, you have to make up a new bureaucracy, advisory committee, new procedures, and so forth, and this is what complicates and slows down the machinery.

Senator Kennedy. Senator Dominick?

Senator Dominick. Thank you, Mr. Chairman.

Doctor, I am sorry I was not here to hear you give your testimony. I have had an opportunity to scan it. You will recall that sometime ago we were discussing possible changes in the organization and the strength of the Public Health Service. Do you feel that without this bill that you really have sufficient money and manpower and training and ability to handle the vaccination programs that are talked about in the proposed bill?

Dr. DuVal. Yes, Sentor, we feel we do under the existing authority.

Senator Dominick. I have had information from a number of areas that I happen to be pretty closely acquainted with which would indicate that the ability to get people to come in for public health service programs for innoculations or vaccinations simply does not work, that you don't get them in.

About the only way you can do it is to outreach and go out to the respective homes, particularly in the lower income ones, and try and do it by personal visits through the medical associations and things of this nature.

Dr. DuVal. I think that is quite true. I think that would be true irrespective of whether the authority was 314 or 317.

Senator Dominick. Yes; but in 314(e) we don't know what you are going to do.

Dr. DuVal. Yes, it is also targeted in projects.

Senator Dominick. It is not targeted with respect to the kinds of vaccinations you should do.

Dr. DuVal. We could break down any program in 314(e) you would wish. That is completely within our jurisdiction. It is the same as 317.

Senator Dominick. I gather with respect to communicable disease, your opposition to that, you are also opposed to the venereal disease bill we have up. Is that correct?

Dr. DuVal. We are with you in principle and purpose, Senator. I think our objective in being opposed to the bill itself is only that it adds additional authority and another piece of bureaucracy to an authority we already have. It adds nothing new.

Senator Dominick. It strikes me, and maybe I am being oversimplistic in this, that that is part of the usual situation where an agency or executive department says, "Just give us the money, and we will decide what to do with it," whereas Congress is supposed to be determining what you are going to do with the money.

Isn't that really the basis of your objection? You want to have the money, but you don't want to have any controls over what you are supposed to do with it?

Dr. DuVal. So that there is no confusion, could I reiterate, Senator, that, apropos of the allocation of funds under 314(e), this is all done with the budget submitted to Congress so you know precisely what is going out.

Senator Dominick. The Appropriations Committee does. We don't here.

Dr. DuVal. There is no reason you could not have access to that. If we have been delinquent in supplying it, we want to make sure you have it.

Senator Kennedy. Do you have a defined venereal disease prevention and control program?

Dr. DuVal. Yes.

Senator Dominick. Where?

Dr. DuVal. I will ask Dr. Sencer to give that.

Dr. Sencer. We have a program, Senator Dominick, which provides grants to States and local health departments. This will amount to $22.3 million this year in project grants to State and local health departments to specifically increase their activities in screening of individuals for gonorrhea. We have approved treatment facilities in which they are being treated to be sure they get adequate treatment.

Senator Dominick. This is all through the States and local public health departments; right?

Dr. Sencer. Right.

Senator Dominick. You don't make any to local medical associations or other groups that happen to be trying to do something about this?

Dr. Sencer. The State and local health departments do work closely with the local professional societies.

Senator Dominick. Some do; and some don't.

Dr. SENCER. I am sure that is the case, but I think the sort of concerted efforts we are seeing this year between organized medicine and organized public health indicates that they are coming closer together in their goals, and the working climate between local health departments, local medical societies, local specialty groups, all indicate that everyone has a stake in this and are devoting their resources to it.

Senator DOMINICK. It indicates that anybody in the medical profession would have an interest in this, I am sure, and try to do something about it. The question is, if you have a program or if you have an organization which wants to focus in on this type of a problem, in most cases I know the State or local public health personnel are already overstressed, I guess is the best word, in terms of manpower and ability to perform a job, and if you can give a project grant to someone who wants to make it a specialty, what is wrong with that?

Dr. SENCER. The provisions of the bill that you are considering, Senator Dominick, do make provisions for these grants to be made to State health authorities and with concurrence of the State health authorities to political subdivisions of the State.

It is the feeling that venereal disease is a public problem and that the public health departments have a statutory responsibility in this area. There is nothing that restricts further subcontracting by the State and public health authorities to assist them in this fight.

Senator DOMINICK. Do you know any examples where they do in fact subcontract with others?

Dr. SENCER. Yes. I think we could give you many examples.

Senator DOMINICK. In VD?

Dr. SENCER. Yes, in VD in Florida, they have started a VD Awareness Month where the health department is working with a variety of voluntary agencies, the broadcasting association, the State medical society, local medical societies in Dade County, providing them with materials and getting their help in an awareness program to improve public knowledge of venereal diseases.

Senator DOMINICK. Good. That is great for Florida. Do you know anything going on in Massachusetts or Colorado?

Mr. SENCER. I do know that specifically now in Massachusetts, Dr. Fiumara, who is the director of communicable diseases control and also venereal disease control, is very close with the medical society there, and that the medical society in Massachusetts takes a leading role in the venereal disease program.

In Colorado we have this coming year, an increase in the amount of moneys available to the State health department by almost $200,000 to do something about venereal disease.

(At this point Senator Dominick assumed the chair.)

Senator DOMINICK (presiding pro tempore). You say you are going to give $200,000 to the State health department to increase their efforts?

Dr. SENCER. Yes. This will go for new manpower, laboratory services, to support the program for screening, and public education.

Senator DOMINICK. We have four diagnostic clinics in Colorado now. We are not going to get money in this. It is going into the public health service.

Dr. SENCER. It can function through the diagnostic clinics. Part of our strategy is to increase the hours clinics are available, and having

mobile clinics in various less populated areas. The increased use of the so-called free clinics, the neighborhood storefront clinics, and so forth, in the coming year.

Senator DOMINICK. Why do you believe HEW responds faster through 314(e) than through categorical authority?

Dr. DUVAL. I missed about the middle third of your sentence, Senator. I am sorry.

Senator DOMINICK. Why do you say HEW or the Public Health Service can operate quicker through 314(e) than through a categorical authority?

Dr. DUVAL. I don't think that I said that. I might have implied it inadvertently. As long as one has the capacity to reprogram within any authority, the ability to respond promptly should be there either way.

Our point was that we can and have, and indeed are almost regularly reprograming within 314(e) in order to be responsive; the issue that HEW would ask that you consider is whether or not one needs direct project authority under both 314(e) and 317 to achieve the same objective. We submit there is nothing to be gained and something to be lost by duplicating the authority.

Senator DOMINICK. What is there to be lost under the programmatic idea?

Dr. DUVAL. When you go from 314(e) to 317 you now must set up another unit, with its own guidelines, its own Federal Register publications, its own bookkeeping and review procedures after the grants were made.

We already have that authorized under 314(e). Under the circumstances one compounds the capacity of HEW to respond to these areas and we create larger and larger bureaucracies.

Senator DOMINICK. We have a number of categorical communicable disease provisions under the proposed legislation. Which of those are you now operating?

All of them, or just some of them?

Dr. DUVAL. As far as I know, all of them, Senator; isn't that correct?

Dr. SENCER. At the present time in terms of supporting the State and local efforts, we have project grants for venereal disease control atcivity for syphilis and gonorrhea.

We have project grants for German measles, and polio, immunization programs in general. This current fiscal year we will also be supporting grants for the first time in trying to prevent Rh diesase in women who may be sensitized in pregnancy.

Senator DOMINICK. You said you could do this?

Dr. SENCER. We are doing this.

Senator DOMINICK. We have made as a country, considerable progress in most of these, but obviously VD is on the upward swing, not the downswing. Are you allocating more of the 314(e) funds to this program?

Dr. DUVAL. Very much more. We have increased it up to $31 million this year compared to approximately $9 or $10 million in 1971, and this week we will be submitting to the Congress a request that you increase further the authorization ceiling under 314(e) in order to achieve this and certain other objectives.

Senator DOMINICK. How much is your total authorization and appropriation under 314(e) for the past 2 years?

Dr. DUVAL. 1972, it was $135 million. As of now, 1973, it is $157 million, and we are requesting this week that that be extended from $157 to $179 million.

Senator DOMINICK. The requested increase has been approved as far as the proposed budget; is that correct?

Dr. DUVAL. Yes, sir.

Senator DOMINICK. Do we know what you are going to use the money for?

Dr. DUVAL. Yes, we do, Mr. Chairman. We will be using—let me check that. Mr. Chairman, we may have to break out the information in pieces. The information which I have with me indicates we would be asking for $8.5 million relating to lead base paint poisoning.

The balance as far as I know for the most part is for communicable and venereal diseases. I would have to supply a breakdown of the increase for the record. I did not bring it with me.

Senator DOMINICK. If you will do that, it would be helpful.

(The information referred to follows:)

DISTRIBUTION OF 314(e) AUTHORIZATION FOR 1973

Activities	Current authorization	Additional request	Total
Comprehensive health centers	$100,200,000		$100,200,000
Family health centers	16,000,000		16,000,000
Rubella	10,000,000		10,000,000
Rodent control	15,000,000		15,000,000
Venereal disease	15,800,000	$9,000,000	24,800,000
Other immunization		4,500,000	4,500,000
Lead base paint poisoning		8,500,000	8,500,000
Total	157,000,000	22,000,000	179,000,000

Senator DOMINICK. We have a specific bill for lead-paint poisoning. It seems to me that maybe as a part of what you are saying and what you are requesting in the way of increased budget, you should also give us as a part of that how much of it is going to go into the hiring of new public health personnel, both here and in the various regions.

Dr. DUVAL. We can supply that for the record. I did not bring any—bring down either personnel increase or the dollar break out of the increased authorization being requested under 314(e). I will see that it is supplied.

(The information referred to follows:)

BUREAU OF COMMUNITY ENVIRONMENTAL MANAGEMENT

LEAD-BASED PAINT

	1972		1973	
	Positions	Amount	Positions	Amount
Direct operations	38.1	$1,026,600	38.1	$1,220,100

Senator DOMINICK. Thank you very much, Doctor.

Dr. DUVAL. Thank you, Mr. Chairman.

Senator DOMINICK. Senator Javits is unable to be here today. He

has a statement as the author of the venereal disease bill, and at this point, since I seem to be the only one here, I will authorize that this be included in the record.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Mr. Chairman, I am the author of S. 3187, the "National Venereal Disease Prevention and Control Act," which is cosponsored by the chairman and has the bipartisan support of more than 40 Senators. I am also a cosponsor of S. 3442, "The Communicable Disease Control Amendments Act of 1972," introduced by the chairman. I am, therefore, particularly pleased and commend the chairman for initiating hearings on both of these important legislative measures.

I share the concern expressed by the chairman that we must take more effective action against the toll being taken on this country by communicable diseases and that the funding authorizations provided under the legislative authority of section 317 has not been requested.

Once again, venereal disease is sweeping New York State and the Nation in epidemic proportions. Insanity, blindness, paralysis, and even unborn infants are not immune from its ravages. The two most dreaded and prevalent forms of venereal disease, syphilis and gonorrhea, pose a vast problem that ignores socio-economic lines and penetrates affluent suburbs as well as impoverished inner city ghettos.

The statistics are absolutely startling and shocking. Some 650,000 new cases of venereal disease were reported in 1971. But because most cases of VD are not officially reported, the National Commission on Venereal Disease estimates that 80,000 cases of infectious syphilis and 2.2 million cases of gonorrhea occurred last year. In New York State—which ranks fifth among States for per capita incidence of syphilis and 17th for gonorrhea—there were 53,000 reported cases of VD and an estimated 400,000 actual cases in 1970, the most recent year for which complete figures are available. The VD epidemic is growing at an alarming rate with no sign of letup. And so are the costs. Treatment of syphilitic insanity and blindness now exceeds $45 million a year nationally, and the impact of VD on lost income and absenteeism may be as high as $1 billion annually.

Just last week, the report of the National Commission on Venereal Disease revealed that reported cases of gonorrhea have increased yearly at the alarming rate of 10 to 15 percent and after 4 years of decreasing, infectious syphilis increased. I ask unanimous consent that the full text of the report be made part of the hearing record.

The report emphasized the importance of increased funding for treatment, prevention, education, and control of VD and many of the recommendations of the report correspond with the provisions of my bill.

I believe that because of an at best spotty Federal record in combatting it, VD remains an epidemic of unparalleled proportions. Last year, only $6.3 million in Federal funds was funneled into the fight, although this was increased by $16 million this year—still far short of what is needed. Ironically and tragically, the tide of battle began to shift against us, and funding for Federal VD prevention and treatment programs was cut back rather than stepped up. The result was an increase in the rate of VD infection more rapid than ever before,

with State and local health authorities left to continue the fight with less money than they had before.

There can be no question that as funding is reduced, VD increases. In 1970, the number of cases of syphilis in New York State was 40 percent higher than it was in 1969. In 1971, we saw an additional increase of about 15 percent. One obvious question that arises is why are we not doing as well now as we were in the early 1950's. The answer is that New York, like most other States, relies very heavily on Federal support for VD control. New York State during the early 1950's received a considerable amount of Federal support for syphilis control activities, but toward the end of the 1950's this support was drastically reduced with a consequent rise in the number of cases of syphilis. Federal support was again increased in 1962–63 and there then resulted a striking decline in the number of cases. In the last 2 years, our Federal support has been declining once again and we are now seeing the result of this lack of support. Thus, the direct correlation between the incidence of syphilis and the level of support can be readily seen.

The answer to what has caused the current epidemic thus leads to one obvious answer as to how to deal with it. Material Federal aid for prevention and treatment programs is desperately needed. My bill will authorize $15 million annually in technical assistance and grants to universities, hospitals and other public or private nonprofit entities; $25 million annually in formula grants for the establishment of comprehensive State venereal disease diagnosis and treatment programs; and annual grants of $30 million to States and political subdivisions for VD prevention and control programs set up along strict Federal guidelines.

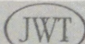
My bill, as indicated by the national commission report, is part of the answer. But, unless there is a vast increase in public support for such massive efforts as this against VD—and greater public understanding of the disease and sympathy for its victims—the struggle to conquer VD cannot be won.

Few dispute that the widespread incidence of venereal disease, especially among young people, is a direct outgrowth of today's so-called sexual revolution. While the increased promiscuity and permissiveness of this revolution should not be condoned, nor should the tragic consequences of this revolution for millions of Americans be ignored. VD now reaches into every level of society. As one VD investigator for a California clinic has put it, "Prostitution is not where it's at with VD today. It's Johnny next door and Susie up the street."

Public attitudes toward syphilis and gonorrhea must start changing—and changing fast. Americans can no longer afford outmoded notions of VD as something dirty and immoral, rather than as the contagious and crippling disease that it is. Without public support for meaningful health education in our schools that will make clear to teenagers the peril of VD, and without public support for stepped-up medical research that could result in the development of a VD vaccine—all the new laws in the world cannot succeed in putting VD where it belongs: in the history books of conquered diseases.

An example of advertising which makes clear to parents and teenagers the peril of VD and the need for prompt medical care was a public affairs television commercial by BC/BS. I ask unanimous consent that the story board of the commercial be printed in the hearing record along with the text of S. 3187.

(The information referred to follows:)



420 LEXINGTON AVENUE
NEW YORK 17

CLIENT: WASHINGTON BLUE CROSS/BLUE SHIELD

TITLE: "V.D." (WASHINGTON VERSION)
CODE NO.: XGVW1036
JO# 510092

DATE: 1/10/72
LENGTH: 60 SECONDS

1. (SFX: PHONE RINGS)

2. GIRL: Hello...

3. oh hi, Larry.

4. Something wrong?

5. You think what?

6. V.D......

7. Then ah I must have it too.

8. What will I do?

9. My parents...

10. (SFX)

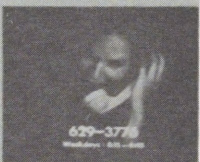
11. I wish I knew....

12. ANNCR: Venereal disease can make you sterile,

13. crippled,

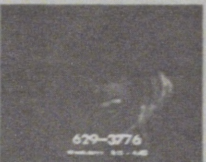
14. blind,

15. or dead.



16. See your doctor,

17. or call this number



18. for a free confidential examination.

19. We believe

20. there's more to good health than just paying bills.

92d CONGRESS
2d Session

S. 3187

IN THE SENATE OF THE UNITED STATES

February 17, 1972

Mr. Javits (for himself, Mr. Kennedy, Mr. Williams, Mr. Dominick, Mr. Brooke, Mr. Cranston, Mr. Beall, Mr. Cannon, Mr. Case, Mr. Eagleton, Mr. Gurney, Mr. Harris, Mr. Hart, Mr. Hollings, Mr. Hughes, Mr. Humphrey, Mr. McGee, Mr. McGovern, Mr. Mondale, Mr. Moss, Mr. Nelson, Mr. Pastore, Mr. Percy, Mr. Randolph, Mr. Ribicoff, Mr. Stafford, Mr. Stevens, Mr. Stevenson, Mr. Taft, Mr. Tower, Mr. Tunney, and Mr. Young) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act so as to provide for the prevention and control of venereal disease.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 SHORT TITLE
4 Section 1. This Act may be cited as the "National
5 Venereal Disease Prevention and Control Act".
6 FINDINGS AND DECLARATION OF PURPOSE
7 Sec. 2. (a) The Congress finds and declares that—
8 (1) the number of reported cases of venereal dis-
9 ease has reached epidemic proportions in the United
10 States;

(2) the number of patients with venereal disease reported to public health authorities is only a fraction of those treated by physicians;

(3) the incidence of venereal disease is particularly high among individuals in the 20–24 age group, and in metropolitan areas;

(4) venereal disease accounts for needless deaths and leads to such severe disabilities as sterility, insanity, blindness, and crippling conditions;

(5) the number of cases of congenital syphilis, a preventable disease, in infants under one year of age increased by $33\frac{1}{3}$ per centum between 1970 and 1971;

(6) health education programs in schools and through the mass media may prevent a substantial portion of the venereal disease problem; and

(7) medical authorities have no successful vaccine for syphilis or gonorrhea and no blood test for the detection of gonorrhea among the large reservoir of asymptomatic females.

(b) In order to preserve and protect the health and welfare of all citizens, it is the purpose of this Act to establish a national program for the prevention and control of venereal disease.

1 AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

2 SEC. 3. (a) Part B of title III of the Public Health
3 Service Act is amended by adding immediately after section
4 317 thereof the following new section:

5 "PROJECTS AND PROGRAMS FOR THE PREVENTION
6 AND CONTROL OF VENEREAL DISEASE

7 "SEC. 318. (a) The Secretary is authorized to conduct,
8 and render assistance to appropriate public authorities and
9 scientific institutions in the conduct of research, training,
10 and public health programs relating to the prevention and
11 control of venereal disease.

12 "(b) (1) The Secretary is authorized to make grants
13 to States, political subdivisions, universities, hospitals, and
14 other public or nonprofit private institutions, agencies, insti-
15 tutions, or organizations, for projects for the conduct of re-
16 search, demonstrations, or training for the prevention or
17 control of venereal disease.

18 "(2) For the purpose of carrying out this subsection,
19 there is authorized to be appropriated the sum of $15,-
20 000,000 for the fiscal year ending June 30, 1973, and for
21 each of the next two succeeding fiscal years.

22 "(c) (1) There is authorized to be appropriated the
23 sum of $25,000,000 for the fiscal year ending June 30,
24 1973, and for each of the next two succeeding fiscal years,

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1 to enable the Secretary to make grants to State health au-
2 thorities to assist the States in establishing and maintaining
3 adequate public health programs for the diagnosis and treat-
4 ment of venereal disease. The sums so appropriated shall be
5 used for making payments to States which have submitted,
6 and had approved by the Secretary, State plans for the pro-
7 vision of public health services for the diagnosis and treat-
8 ment of venereal disease.
9 "(2) In order to be approved under this subsection, a
10 State plan for the provision of public health services for the
11 diagnosis and treatment of venereal disease must—
12 "(A) provide for the administration or supervision
13 of administration by the State health authority;
14 "(B) set forth the policies and procedures to be
15 followed in the expenditure of the funds paid to the
16 State under this subsection;
17 "(C) provide that the public health services fur-
18 nished under the plan will include the provision of State-
19 wide laboratory services which include Darkfield micro-
20 scopes for the diagnosis of both gonorrhea and syphilis,
21 and will otherwise be in accordance with standards pre-
22 scribed by regulations, including standards as to the scope
23 and quality of such services;
24 "(D) contain or be supported by assurances satis-
25 factory to the Secretary that (i) the funds paid to the

1 State under this subsection will be used to make a sig-
2 nificant contribution toward providing and strengthen-
3 ing public health services for the diagnosis and treat-
4 ment of venereal disease in the various political subdivi-
5 sions in order to improve the health of the people; (ii)
6 such funds will be used to supplement and, to the extent
7 practical, to increase the level of funds that would other-
8 wise be made available for the purposes for which the
9 Federal funds are provided and not to supplant any non-
10 Federal funds which would otherwise be available for
11 such purpose; and (iii) the plan is compatible with the
12 total health program of the State;
13 "(E) provide that the State health authority will
14 from time to time, but not less often than annually, re-
15 view and evaluate its State plan approved under this
16 subsection, and submit to the Secretary appropriate
17 modifications thereof;
18 "(F) provide that the State health authority will
19 make such reports, in such form and containing such in-
20 formation, as the Secretary may from time to time
21 reasonably require, and will keep such records and afford
22 such access thereto as the Secretary finds necessary to
23 assure the correctness and verification of such reports;
24 "(G) provide for such fiscal control and fund ac-
25 counting procedures as may be necessary to assure the

1 proper disbursement of and accounting for funds paid to
2 the State under this subsection; and
3 "(H) contain such additional information and assur-
4 ances as the Secretary may find necessary to carry out
5 the purposes of this subsection.
6 "(3) From the sums appropriated to carry out the pro-
7 visions of this subsection, the several States shall be entitled
8 for each fiscal year to allotments determined, in accordance
9 with regulations, on the basis of the incidence of venereal
10 disease in, and the population of, the respective States; ex-
11 cept that no State's allotment shall be less than $50,000 for
12 any fiscal year.
13 "(4) (A) From each State's allotment under this sub-
14 section for a fiscal year, the State shall be paid a Federal
15 share of the expenditures incurred during such year under its
16 State plan approved under this subsection. Such payments
17 shall be made from time to time in advance on the basis of
18 estimates by the Secretary or by way of reimbursement,
19 with necessary adjustments on account of previous under-
20 payments or overpayments.
21 "(B) The Federal share for any State shall be such
22 per centum (not in excess of 90 per centum) of the expendi-
23 tures of such State (referred to in subparagraph (A)) as
24 shall be established by such State.

1 "(C) 'State' means each of the several States of the
2 United States, the District of Columbia, the Virgin Islands,
3 Guam, American Samoa, Trust Territory of the Pacific
4 Islands, and the Commonwealth of Puerto Rico.
5 "(D) Any amount so allotted to a State during any such
6 fiscal year (other than the Virgin Islands, American Samoa,
7 Guam, the Trust Territory of the Pacific Islands, and the
8 Commonwealth of Puerto Rico) and remaining unobligated
9 at the end of such year shall remain available to such State,
10 for the purposes for which made, for the next fiscal year
11 (and for such year only) and any such amount shall be in
12 addition to the amounts allotted to such State for such pur-
13 pose for such next fiscal year; except that any such amount
14 remaining unobligated at the end of the sixth month follow-
15 ing the end of such year for which it was allotted which
16 the Secretary determines will remain unobligated by the
17 close of such next fiscal year may be reallotted by the Secre-
18 tary, to be available for the purposes for which made until
19 the close of such next fiscal year, to other States which have
20 need therefor, on such basis as the Secretary deems equitable
21 and consistent with the purposes of this subsection, and any
22 amount so reallotted to a State shall be in addition to the
23 amounts allotted and available to the States for the same
24 period. Any amount allotted under this subsection of this
25 section to the Virgin Islands, American Samoa, Guam, the

1 Trust Territory of the Pacific Islands, or the Commonwealth
2 of Puerto Rico for a fiscal year and remaining unobligated
3 at the end of such year shall remain available to it for the
4 purposes for which made, for the next two fiscal years (and
5 for such years only), and any such amount shall be in addi-
6 tion to the amounts allotted to it for such purpose for each of
7 such next two fiscal years; except that any such amount, re-
8 maining unobligated at the end of the first of such next two
9 years, which the Secretary determines will remain unobli-
10 gated at the close of the second of such next two years,
11 may be reallotted by the Secretary, to be available for the
12 purposes for which made until the close of the second of
13 such next two years, to any other of such named States which
14 have need therefor, on such basis as the Secretary deems
15 equitable and consistent with the purposes of this part, and
16 any amount so reallotted to any such named State shall be
17 in addition to any other amounts allotted and available to it
18 for the same period.

19 "(d) (1) The Secretary is authorized to make project
20 grants to States and, with the approval of the State health
21 authority, to political subdivisions of States, for the conduct
22 of venereal disease prevention and control programs.

23 "(2) For purposes of this subsection, the term 'vene-
24 real disease prevention and control program' means a pro-
25 gram which includes—

1 "(A) disease surveillance activities, including the
2 reporting, screening, and followup of diagnostic tests
3 and diagnosed cases of venereal disease;
4 "(B) casefinding and case followup activities,
5 including contact tracing of infectious cases;
6 "(C) interstate epidemiologic referral and follow-
7 up activities;
8 "(D) professional and public venereal disease edu-
9 cation activities; and
10 "(E) such special studies or demonstrations to
11 evaluate or test venereal disease control as may be pre-
12 scribed by the Secretary.
13 "(e) Grants made under subsection (b) or (d) of
14 this section shall be made on such terms and conditions as
15 the Secretary finds necessary to carry out the purposes of
16 such subsection, and payments under any such grants shall
17 be made in advance or by way of reimbursement and in such
18 installments as the Secretary finds necessary.
19 "(f) Nothing in this section shall be construed to limit
20 or otherwise restrict the use or availability of funds which
21 are granted to a State or to a political subdivision of a State
22 under other provisions of this Act or any other Federal law
23 and which are available for the conduct of venereal disease
24 programs from being used in connection with programs as-
25 sisted through grants under this section.

1 "(g) For the purpose of carrying out this subsection,
2 there is authorized to be appropriated the sum of $30,000,-
3 000 for the fiscal year ending June 30, 1973, and for each
4 of the next two succeeding fiscal years.

5 "(h) Each recipient of assistance under this section
6 shall keep such records as the Secretary shall prescribe, in-
7 cluding records which fully disclose the amount and disposi-
8 tion by such recipient of the proceeds of such assistance, the
9 total cost of the project or undertaking in connection with
10 which such assistance is given or used, and the amount of
11 that portion of the cost of the project or undertaking sup-
12 plied by other sources, and such other records as will facili-
13 tate an effective audit.

14 "(i) The Secretary and the Comptroller General of the
15 United States, or any of their duly authorized representa-
16 tives, shall have access for the purpose of audit and examina-
17 tion to any books, documents, papers, and records of the re-
18 cipients that are pertinent to the assistance received under
19 this section.

20 "(j) The Secretary, at the request of a recipient of a
21 grant under this section, may reduce such grant by the fair
22 market value of any supplies, or equipment furnished to such
23 recipient and by the amount of pay, allowances, traveling
24 expenses, and any other costs in connection with the detail
25 of an officer or employee to the recipient when the furnish-

1 ing of such supplies or equipment, or the detail of such officer
2 or employee (as the case may be), is for the convenience of
3 and at the request of such recipient and for the purpose of
4 carrying out the program with respect to which the grant
5 under this section is made. The amount by which any such
6 grant is so reduced shall be available for payment by the
7 Secretary of the costs incurred in furnishing the supplies,
8 equipment, or personal services on which the reduction of
9 such grant is based, but such amount shall be deemed a part
10 of the grant to such recipient and shall, for the purposes of
11 this section, be deemed to have been paid to such agency."
12 (b) Section 314 (d) (2) of the Public Health Service
13 Act is amended—
14 (1) by striking out ", and" at the end of clause
15 (K) and inserting in lieu thereof ";";
16 (2) by striking out the period at the end of clause
17 (L) and inserting in lieu of such period "; and"; and
18 (3) adding after clause (L) the following new
19 clause:
20 "(M) effective July 1, 1973, provide for services
21 for the prevention and control of venereal disease.".

Senator DOMINICK. At this point we will receive for the record a statement from Senator Hart of Michigan.

PREPARED STATEMENT OF HON. PHILIP A. HART, A U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator HART. Mr. Chairman, it isn't often we have a chance to testify in favor of a program that has proved as successful as the Federal Vaccination Assistance Act.

Between 1966 and 1968 the number of reported measles cases nationally dropped from 204,136 to 22,231. Over that span, the percent of children under four susceptible to measles dropped from 41 percent to less than 34 percent.

Victory over measles was in sight.

Unhappily, in 1968 the Department of Health, Education, and Welfare changed the administration of this program.

Since then, the number of reported cases jumped to 69,948 for the first 9 months of 1971 alone; the susceptible percentage rose to 38 percent.

These figures were reported to me by the U.S. Center for Disease Control in Atlanta, Ga. I ask that the data from the Center be included in the record.

As has been explained to your subcommittee by medical personnel more knowledgeable in this area than I, the change was the result of debates within the administration over whether money allocated categorically through this program, as done before 1968, would work as effectively as funds allocated under the block-grant approach of the partnership for health program, as done since 1968.

There should be no further doubt of the more effective method. The record is clear that disease rates were greatly reduced during the 6 years successful experience of categorical funding from the Vaccination Assistance Act. Partnership funding has been given an adequate 3-year trial and has not shown any successes in this health area. Disease rates have gone up, the number of unimmunized children has increased, epidemics in diphtheria and measles have been numerous and venereal disease is rampant throughout the country.

Four years ago there were 5 million unimmunized children against measles. Now there are 13 million measles-susceptible children. In 1968, 260 persons developed diphtheria while in 1970 it attacked 435 persons. Gonorrhea rose from 464,543 in 1968 to 600,072 in 1970, and syphilis is on the increase at the rate of 12 percent per year.

There are no grounds to continue the argument in favor of partnership funding to States in these categories, since disease knows no geographical boundaries. In this very mobile Nation, the preventable infectious diseases of children, tuberculosis and venereal disease demand a national responsibility.

Evidently what has happened under the block-grant approach is that as the number of reported cases of the various communicable

diseases decreased, other demands for partnership in health funds gained precedent at local and State levels. But again, the only way to prevent the spread of communicable diseases, particularly in a nation with a mobile population, is to continue high levels of immunization regardless of how few cases of a particular disease may be reported in a particular area.

It is obvious from experience that no matter how necessary local decision-making may be for certain medical problems, the prevention of communicable diseases among a mobile population should be attacked on a national basis.

Even more importantly, experience has shown that if money is made available for vaccination programs, the vaccinations reach the children.

I hope the administration will change its decision to appose extension of the Federal Vaccination Assistance Act.

Let us not retreat from the brink of victory against measles, and let us mount as an effective drive against other communicable diseases.

I urge the subcommittee to report favorably S. 3442.

And I will support the administration's budget request for $179 million for the Partnership program, but I feel strongly that Congress should provide an additional $90 million for the categorical vaccination programs.

Thank you.

STATEMENT ON MEASLES (RUBELLA) OCCURRENCE AND FEDERAL ASSISTANCE FOR IMMUNIZATION PROGRAMS

Table I indicates the population, the number of children who received measles (rubella) vaccine, the number of children contracting measles, and the remaining percent susceptible to measles by age group in the United States, 1966 through 1970. In the age group 1–4, the remaining percent susceptible was 41.0 in 1966. This was reduced to 33.1 percent in 1969. However, in 1970 the percent susceptible increased to 37.7. Data for 1971 are not yet available. When these data are available, it is expected that the 1–4 year age group will show a further increase of children unprotected against measles.

Table II includes the number of doses of measles vaccine provided by Vaccination Assistance Act grant funds and used by States and communities in fiscal years 1966 through 1969. Use of vaccine under this authority was restricted to the preschool population. During fiscal years 1966 through 1969 more than 50 percent of preschool children immunized against measles received vaccine from Federal project grant resources. Table II indicates the Authorization, Executive Branch Requests, Appropriations, and Allocations of Funds for immunization programs for fiscal years 1966 through 1972. From July 1, 1969 to April 27, 1971, Federal grant assistance to States and communities was restricted to the control of rubella under Section 314(e) of the Partnership for Health legislation. However, at that time, concern about the resurgence of measles and the decreasing immunization levels resulted in a decision by the Department of Health, Education, and Welfare to permit the expenditure of $4.8 million of 314(e) grant funds for measles vaccine.

Table III shows reported cases of measles in the United States for the period 1966 through September 25, 1971. Based on data from investigation of measles epidemics and other surveillance activities, the incidence of measles far exceeds the number of reported cases.

The decision to assist States and communities by providing measles vaccine from existing grant resources should have a significant impact on checking the measles upward trend in the United States.

TABLE I.—NUMBER AND PERCENT WITH HISTORY OF MEASLES (RUBELLA) VACCINE, PERCENT WITH HISTORY OF MEASLES VACCINE AND/OR INFECTION, AND PERCENT SUSCEPTIBLE, UNITED STATES, 1966–70

Year and age group	Population	Number with history of vaccine	Percent with history of vaccine	Percent with history of vaccine and/or infection	Percent susceptible
1966:					
1 to 4	16, 091, 000	7, 321, 405	45. 5	59. 0	41. 0
5 to 9	20, 436, 000	5, 722, 080	28. 0	NA	NA
10 to 13	NA	NA	NA	NA	NA
1967:					
1 to 4	15, 552, 000	8, 771, 328	56. 4	66. 2	33. 8
5 to 9	20, 851, 000	8, 511, 288	40. 8	NA	NA
10 to 13	16, 022, 000	2, 787, 828	17. 4	NA	NA
1968:					
1 to 4	14, 994, 000	8, 816, 472	58. 8	66. 0	34. 0
5 to 9	20, 857, 000	10, 511, 928	50. 4	NA	NA
10 to 13	16, 266, 000	3, 773, 712	23. 2	NA	NA
1969:					
1 to 4	14, 393, 000	8, 837, 302	61. 4	66. 9	33. 1
5 to 9	20, 733, 000	12, 232, 470	59. 0	80. 1	19. 8
10 to 13	16, 444, 000	5, 212, 748	31. 7	79. 9	20. 1
1970:					
1 to 4	14, 123, 000	8, 078, 356	57. 2	62. 3	37. 7
5 to 9	20, 421, 000	12, 824, 388	62. 8	70. 8	20. 2
10 to 13	16, 601, 000	6, 275, 178	37. 8	80. 9	19. 1

Source: U.S. immunization survey.

TABLE II.—HISTORY OF IMMUNIZATION PROGRAM'S GRANT BUDGET BY AUTHORIZATION AND FISCAL YEAR

[Dollars in millions]

Authorization	Fiscal year	Requested	Appropriated	Allocated	Number doses measles (rubella) vaccine awarded
Vaccination Assistance Act: Sec. 317(a) (for support against measles (rubella), poliomyelitis, pertussis, and tetanus)	1966	$8. 0	$8. 0	$8. 0	2. 5
	1967	9. 1	9. 1	9. 1	3. 5
	1968	9. 1	9. 1	9. 1	2. 0
	1969				1. 4
Partnership for Health:[1] Sec. 314(e) amount earmarked for rubella control	[2] 1969	9. 6	9. 6	9. 6	
	1970	16. 0	16. 0	16. 0	
	1971	16. 0	16. 0	16. 0	[3] 6. 0
	1972	13. 0	13. 0	13. 0	
Communicable Disease Control Amendments of 1970: Sec. 317 amount earmarked for immunizable diseases	1972	0	4. 0	(4)	

[1] Rubella control grants.
[2] Supplemental appropriation.
[3] See text of statement.
[4] These funds have not been allocated as of Oct. 1, 1971.

TABLE III.—REPORTED CASES OF MEASLES (RUBELLA) IN THE UNITED STATES, JAN. 1, 1966–SEPT. 25, 1971

Year	Cases
1966	204, 136
1967	62, 705
1968	12, 231
1969	25, 826
1970	47, 351
1971 (Jan. 1–Sept. 25)	69, 948

Senator Dominick. Our next witness is James R. Kimmey, M.D., executive director of the American Public Health Association.

STATEMENT OF JAMES R. KIMMEY, M.D., EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. KIMMEY. I would like to make a couple of comments for the record rather than read my statement.

Senator DOMINICK. Proceed as you wish.

Dr. KIMMEY. The American Public Health Association is the largest national organization of public health workers with professional and consumer members. We number some 50,000 members now in our 50 State affiliates and our national organization. We have had a longstanding concern with the prevention of disease, and particularly communicable diseases and venereal diseases. We feel it is the area that is probably one of the greatest success stories in public health in the country.

Much, however, remains to be done. We look at the statistics on immunization levels and on venereal disease, and it seems strange that for the want of relatively small investment financially that these areas, which have a great cost-benefit ratio, are not receiving more attention than they are.

Rather than go into any details on the statistics on these conditions which other witnesses are going to present, I would only say that the American Public Health Association was a participant in the National Commission on Venereal Disease and in the preparation of a report, both of which will be placed before the committee by a later witness.

We agree with the recommendations of these reports. We support the extension of the VD control authority and communicable disease authority as proposed in the bills before the committee today.

At the same time, we find ourselves at least partially in agreement with Dr. DuVal when he says that a comprehensive funding authority is most effective in dealing with the emerging problems. It may seem inconsistent on our part to be supporting a categorical grant program and also holding out for comprehensiveness.

However, we have supported the comprehensive health planning and comprehensive health services programs since their inception in 1966. We feel the problems that have followed and the difficulties in dealing with categorical grants like venereal disease and immunization are not the failure of the comprehensive concept but rather the failure of providing adequate funds for this legislation.

In fiscal 1966 when the programs started, each program had approximately $90 million. We have heard a witness from the administration say this morning they are requesting something on the order of $150 million to $160 million this year. This would have been much more appropriate about 1969 or 1970. It is totally inadequate for today's needs.

Although it would be valuable to handle problems like venereal disease through a 314(e) mechanism, it is too late to catch up this year. We do favor, therefore, extension of the specific authorities, but we should keep in mind that we are now discussing issues like na-

tional health insurance and health maintenance organizations, both of which are to provide comprehensive preventive services. If this is true and if these things come to pass, then there should be a declining need for the categorial type of programs represented by the two bills before the committee today.

Obviously we are talking about something that is going to take years to bring about in terms of national health insurance and health maintenance organizations as far as the whole country is concerned, but I think we need to have this in mind, because successful offering of a HMO alternative, or a successful national health insurance program should over time decrease the needs of these categorical programs represented here.

I would also like to add a specific comment on section 2(h)(1) of S. 3442 on the need for public education in communicable disease. The association strongly supports this concept of adding public education money for this specific activity, and we feel that this is an area that has long been neglected in health education.

We welcome the President's initiative in forming the National Committee on Health Education, but we feel it is very important that along with recommendations, along with suggestions for improving the public's understanding of disease states, that the necessary funding be provided, and it seems like a good first step to include such within this bill. We would hope the committee would consider adding this kind of authority or appropriations for health education to other bills, until such time as a comprehensive program of health education for the whole Nation can be created and funded as one package.

Those are my comments, Mr. Chairman.

Senator DOMINICK. Dr. Kimmey, let me take these bills up one at a time, S. 3442 to start with.

Did I understand that you say that subsection (h) which refers to making grants to public and private nonprofit agencies for, really, educational purposes, is not in accord with your thinking?

Dr. KIMMEY. No, sir. I said that this was entirely in accord with our thinking. It is the type of thing we think ought to be done more often. We do not emphasize often enough public education.

In our view, unless each individual in this country accepts some degree of personal responsibility for his health—personal responsibility for understanding the effects of the things he does every day and how they affect his health, and understanding the effects of disease on him as an individual, that it is going to be that much more difficult to achieve the kind of health status we would like in the American people.

Senator DOMINICK. Do I understand what you are suggesting is that we take subsection (h) and put it in under 314(e) and add some more money?

Is that what you are talking about?

Dr. KIMMEY. This would be possible. What I am really saying is, since you get a number of these relatively categorical grants coming through here, that until such time as we get broad authority for health education, by adding this type of authority to the various categorical programs we can begin to develop at least some type of educational activities federally funded and impacting all the people in the country.

Senator DOMINICK. Maybe I don't understand your testimony and conclusions. Dr. DuVal testified he thought they could do everything under 314 (d) and (e) better than they could under these bills.

I thought you agreed with that.

Dr. KIMMEY. As Dr. DuVal said, ideally, he could do this. We agree that ideally he could do it, but we hare hardly in an ideal situation as relates to 314 (d) and (e). We are trying to say that if 314 (d) and (e) had been adequately funded from the beginning as was indicated at the time they were authorized we might not be back here today to ask for categorical funds.

They have not been, and I think that what we are saying is that this extension of these acts is needed, but we hope it is the last extension that is needed. We would like to see these handled in a comprehensive basis, a part of the health maintenance organization, and so on.

Senator DOMINICK. In your opinion, is there sufficient authorization under 314 (d) and (e) if they were fulfilled in the appropriations process to eliminate the need for the categorical grant processes?

Dr. KIMMEY. No. I think that they are $50 or $60 million behind what they ought to be if you had started adding these on an as-needed basis in 1966.

Senator DOMINICK. In your testimony on page 3, with respect to S. 3187, I gather that you are raising objections to any State plans targeting on communicable disease?

Dr. KIMMEY. Mr. Chairman, this refers to another aspect of the Comprehensive Health Planning Act which tried, and successfully, I think to deal with an entire bookshelf of the State plans that were once necessary for a State health department to qualify for some 16 Federal formula grant funds.

When I was working in HEW, under that particular legislation we literally had bookshelf upon bookshelf full of State plans, some of which had not been changed for years, because they were simply a pro forma requirement.

Under section 314(a) of the Public Health Service Act a comprehensive State plan is prepared and under 314(d) the grant authority, the State health department submits a plan which uses its priorities to determine ways to use the block-grant funds.

We would like to see a requirement, if there is going to be a State plan for venereal disease, that it be added in the 314(d) State planning process and the 314(a) State planning process and the State not be in a position of having to prepare yet another plan.

I suspect the language that is used in this legislation was that used in the old programs before 1966. I hope if we have gotten nothing else from the 314 (a) and (d) process that we have a planning mechanism that can accommodate itself to a targeted request from Congress.

Senator DOMINICK. If we eliminated the requirement for a separate State plan, would you think S. 3187 would be a program that ought to be specifically authorized?

Dr. KIMMEY. Yes, sir.

Senator DOMINICK. I am having difficulty in correlating the thesis that we ought to have block grants which, generally speaking, I agree with, and the fact that the administration witnesses wanted to go that route, and yet the problems we seem to have in making those block-grant programs effective.

Can you give me any insight into this type of problem?

Dr. KIMMEY. Well, I think you have to go back and look at them historically. Back in 1966 when the block grants first came in, there was a total of approximately $78 to $88 million out in categorical formula grant authorities. These were all lumped together when we created section 314(d) with an authorization of about $90 million, and with some promise that it would go up at the rate of $110, $125, $145 in the next 4 years.

What happened, though, when the appropriations came along for the next fiscal year was that the increased request for 314(d) was inadequate to even cover the increase in costs of operating programs existing under the old formula grants.

So then, where the States thought they were going to have some flexibility and ability to respond to problems that they thought were important, they found themselves in a position of being cut back on established programs without being able to program any new types of activities, a destructive process that has continued ever since then, really, in terms of the amount of flexibility with respect to 314(d).

I think it is very easy to condemn the block grant approach on the basis of our experience to 314(d). I think this is unfair. I don't think it has been adequately funded nor have the States had an opportunity to show what they can do if they could really apply their own priorities in terms of using health funds.

I don't know whether that is an insight into what has happened. I think the block-grant mechanism has gotten a bad name. It has a reputation of being inadequate to deal with serious problems, when perhaps the major problem has been the lack of adequate appropriations.

I think the States know what their health problems are, but they have not been given the opportunity to perform under section 314.

Senator DOMINICK. What about the ability of States through their separate agencies to be able to contract with private organizations or medical associations to have accomplished what we are seeking to accomplish in the legislation?

Are they capable of doing that at the present time? Is there sufficent authority for them to begin with?

Dr. KIMMEY. They could under 314(d) contract funds to other nongovernmental agencies or to local communities if they have the procedures within their States.

Indeed, the current requirements under 314(d) is that 70 percent of these moneys do go to activities in the community level.

Senator DOMINICK. Then I gather the net result of your testimony is that we would do better by increasing the authorization and then moving ourselves by the appropriation process and make sure the money is appropriated rather than going the categorical grant route as provided in this bill?

Dr. KIMMEY. I would say, again, in an ideal situation, that would be true, but we are so far behind in terms of appropriations for these bills, that I don't think asking for the kinds of appropriations that are needed would be realistic at this point in time.

We are living with 8 years of bad history in terms of appropriations here. I think that, as I have said earlier, we like the idea of having major efforts in the VD control area and the immunization and communicable disease areas.

We feel these are badly needed, and I think at this point in time, the categorical approach is the best one available.

But we would hope this is the last time we have to do this, and that by strengthening over time the existing comprehensive legislation that we might be able to achieve a time when we don't need categorical programs like this.

Senator DOMINICK. I don't wish to be difficult, but if we go into the appropraitions process with categorical grants and the Appropriations Committee then hears that they can do the same thing under existing authority, you are going to have trouble getting money for the categorical grants as well as the 314(e).

Dr. KIMMEY. You could do these things under 314(e). This is possible. But because those authorities are inadequately funded, when you start applying Federal priorities to them as well as priorities of the applicants, there is not enough to provide what is needed into these kinds of programs.

The other problem of 314(e) is that we see a great deal of reprograming in order to respond to the Federal priorities of the moment, health maintenance organizations, for example, and this makes it a little more difficult to handle long-standing priorities like venereal disease control and tuberculosis control.

It seems to us comprehensive approaches will work only in the face of totally adequate funding, and that is not in the picture at this point.

Senator DOMINICK. Thank you, Dr. Kimmey. I think that is very helpful testimony. I appreciate your giving it to us.

(The prepared statement of Dr. Kimmey follows:)

78-669 O—72——5

STATEMENT ON
CONTROL OF COMMUNICABLE DISEASES
BEFORE THE
SUBCOMMITTEE ON PUBLIC HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
by

JAMES R. KIMMEY, M.D.
Executive Director
American Public Health Association

Mr. Chairman and Members of the Committee:–

I am Dr. James R. Kimmey, Executive Director of the American Public Health Association, a national organization of individuals deeply concerned with the quality of health services offered the American people. Our Association–which this year celebrates its Centennial–is the nation's largest and oldest public health organization. Since the story of the control of communicable diseases represents one of the finest chapters in the history of public health in the United States, we are particularly pleased to have this opportunity to present our views on the Communicable Disease Control and Vaccination Assistance Act of 1972 (S. 3442) and on the National Venereal Disease Prevention and Control Act (S. 3187). Among the many deficits in the quality and availability of health care offered our American public, perhaps none is so damning as the inadequate control of communicable diseases as manifested in declining vaccination levels and increasing incidence of preventable diseases such as measles, poliomyelitis, tuberculosis, and diptheria. Despite the fact that we have the means at our disposal for control and virtual elimination of these diseases from the population, we are faced by the paradox of their continued occurrence. This results not from a lack of technology or a need for great amounts of financial assistance, but rather from a lack of commitment to the relatively modest financing needs for adequate prevention and immunization programs. When one considers the obvious benefits that accrue from an investment in immunization programs, it is difficult to square present deficiences with the oft-stated national commitment to health care as a basic human right.

It would not be helpful to recount here the statistics on declining vaccination levels, increasing outbreaks of preventable disease, and continued public apathy toward these conditions that have been well documented by others appearing before the committee. The current proposal for extension of the Vaccination Assistance Program of the Federal Government and for expansion of Communicable Disease Programs is a valuable public

health measure that should be enacted. We would hope, however, that this is the last time that the Congress finds it necessary to come to the rescue of a categorical program for communicable disease control and vaccination assistance at the eleventh hour.

This last sentiment requires some explanation. The American Public Health Association has been a consistent supporter of the concept of comprehensive health planning and of block grants to states for programs of public health importance. Our support for this concept was manifest at the time of the enactment of Public Law 89-749 in 1966 and remains strong. If I may recall some history, the theory in 1966 was that the enactment of block grant authority under section 314(d) of the Public Health Service Act would obviate the need for continued categorical funding–a major factor contributing to the fragmentation and discontinuity of health service programs in the United States. In theory, state health agencies would be able to program block grant funds under 314(d) for programs of import to the states such as communicable disease control and venereal disease control and to exercise some degree of autonomy in deciding the relative emphasis to be placed on various public health programs. In practice, the inadequate appropriations requested by successive administrations and granted by the Congress for the implementation of Section 314(d) have doomed the block grant concept to relative inadequacy without an adequate trial. It quickly became obvious that in the face of an unwillingness to commit adequate funds for block grants to state health agencies, categorical funding would have to be continued if we were not to lose ground in several basic areas of public health programming. If the spirit of Public Law 89-749 had been followed, there would be no need for this narrow categorical legislation today.

Further, as the Congress hears arguments pro and con on the issues of national health insurance and health maintenance organizations, the need and the appropriateness of these types of categorical programs again comes into question. Hopefully, between now and the time that these programs again come up for renewal, the national concern for a more rational high quality health care delivery system which includes prevention of disease as an integral part of every individuals' right to health, will have found expression in a comprehensive and coordinated program for the financing and delivery of health services. Under such circumstances, and with due attention to the importance of prevention in a national health program, these types of categorical grants should become truly redundant and of historical interest only.

In addition to these general comments on the relationship of communicable disease control activities to the overall health services delivery system, we would like to offer a few specific ideas for the Committee's consideration. First, we would like to lend our whole-hearted support to that portion of S. 3442 that deals with public education in the area of communicable disease. This new emphasis on public education is welcome indeed. Our Association is convinced that the development of a sense of personal responsibility for health on the part of every citizen is an essential prerequisite to really improving health indicies and health services in this country. The individual needs not only to know the facts about prevention of disease but also to put them into practice. There are many opportunities in the communicable disease field and other aspects of personal health for individual decision making to promote and enhance individual health. One only needs to point to examples like automotive seatbelts, cigarette smoking, and inappropriate eating habits as areas of individual decision with implications for individual health. At the time of the President's Health Message in 1971, when the concept of a National Health Education Foundation was introduced, we supported the idea but questioned whether such an effort would be successful without the infusion of Federal funds for development and dissemination of educational materials. This provision of S. 3442 would make it possible for Federal funds to be invested in public education on communicable disease. We feel that this committee–which reviews most health legislation–should consider the incorporation of similar language into other categorical programs until such time as an overall national effort in health education is designed, structured, and funded.

In the case of S. 3187, the effectiveness of the well-stated preamble and the adequate authorizations is materially weakened by a return, in Section 318(c)(2), to a hopefully archaic form–a disease-specific state plan requirement in order to qualify for Federal formula grant funding. One of the important thrusts of the comprehensive health planning legislation in 1966 was to unify state health planning in a single state agency and to consolidate the various categorical plans into a single state plan for health services. Each state has strived to develop a state health planning process under the impetus of Section 314(a) of the Public Health Service Act. This effort to eliminate the chaos of many different state planning requirements under different Federal funding authorities has borne important fruit. We would strongly urge that, if S. 3187 is enacted, the requirements for a separate state plan be stricken and the state required to cover the venereal disease program planning as an integral part of the overall planning processes already conducted

under the provisions of Sections 314(a) and 314(d) of the Public Health Service Act. The effect, we believe, would be to achieve what the Congress desires and the nation needs–targeted funding of venereal disease control–without a regressive return of categorical state health planning.

We have appreciated this opportunity to appear before the Committee and present our views on these important legislative proposals. We will be happy to answer any questions you might have.

Senator DOMINICK. Our next witness is Dr. Bruce Webster, Cornell University School of Medicine and president, American Social Health Association, together with Dr. John Hume, dean, School of Public Health, Johns Hopkins University, on behalf of the American Social Health Association.

STATEMENT OF BRUCE WEBSTER, M.D., CORNELL UNIVERSITY SCHOOL OF MEDICINE, AND JOHN HUME, M.D., SCHOOL OF PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, ON BEHALF OF THE AMERICAN SOCIAL HEALTH ASSOCIATION

Dr. WEBSTER. Somewhere in the Commission report someone pointed out that the curve of VD rates in the United States is an inverse ratio to Federal funding. As Dr. Duval has already mentioned gonorrhea is epidemic, that there are probably 2½ million cases, and that syphilis is rising.

This is in spite of the fact that we know the organisms that cause these diseases and we have a means of treating them. The concept of a national commission arose in 1969 when the American Medical Association, the American Social Health Association and various other groups got together in Chicago and discussed the alarming increase in rates.

The commission was established in February 1971, by the assistant Secretary of Health, Education, and Welfare. Represented on this commission is the American Medical, the American Osteopathic, the American Public Health Associations, the American Social Health Association, and most of the other groups concerned in the management of venereal diseases.

We have drawn heavily on the National Institute of Health, the Center for Disease Control and the National Institute of Mental Health, as well as a great many private consultants.

We concerned ourselves first with the problem of research, the scarcity of research in the problems of venereal disease. If a fraction of the effort of research that went into polio had gone into these diseases, we would be further ahead.

We don't have a really adequate test for the diagnosis of gonorrhea. A great deal more research can be done in the matter of prophylaxis. Dr. John Cutler is working on this, but this research is very inadequately funded. There is need for further research in the behavioral sciences, so that we know more about the high risk groups.

All of this necessitates funding for greater extramural research. We need to interest the immunologists throughout the country. The commission has recommended $6.5 million for 1973, escalating to over $19 million in 1976. It has been suggested that we might do research into the present control methods. Are they the best methods? These should be evaluated. The commission concerned itself with education. There is a great scarcity of professional manpower in the venereal disease field.

Recently this country was visited by experts from the World Health Organization. They have issued a report which is in the process of being liberated at the present time. This report substantiates this finding.

On the basis of these findings of the National Commission it is suggested that teaching grants be made available to medical schools and

schools of public health in an effort to bring back the teaching of these diseases into the curriculum of the schools.

It has been suggested that the clinics be brought back into the university and community hospitals.

The Commission made recommendations in regard to strengthening venereal disease education in schools. We made recommendations with regard to public education. It has been felt strongly that an all out campaign in public education is necessary. It must be direct, it must reach the high risk groups, and they must be told plainly what the problems are, and where to go. Other countries have done excellent jobs in this regard.

The Commission has recommended that we urgently need earmarked funds for both research and professional and public education. Because of the liability of these funds to be lost in State capitals, it is urged that they be earmarked. The problem of increased grants to States has been discussed earlier. It is felt that the public clinics need strengthening, as Dr. Sencer has pointed out.

They need better qualified professional manpower, better diagnostic facilities for the practicing physicians, since the practicing physicians are the keynote of this disease control program. Lastly, the Commission recommended that an on-going commission composed of representatives of governmental and private medicine be appointed to advise the Secretary of HEW on appropriate research and control measures designed to reduce the incidence of venereal diseases.

Dr. Hume will discuss the problem of funding as recommended by the Commission.

Dr. HUME. Mr. Chairman, the Commission did look very carefully not only to the elements of the program which Dr. Webster has outlined, but did try to come up with reasonable estimates of the amount of money that could be effectively used, and at the same time would be adequate to mount a successful attack on the venereal diseases, a program covering project grants to States and operating funds for the Federal establishment, public and professional education and venereal disease research.

Interestingly enough, the total figures that we arrived at are well within the limits of the bill that is proposed by Senator Javits and yourself and others. On the other hand, there is a slightly different distribution. You have received a copy of the Commission report to be, hopefully, entered as part of our testimony. In that, you find we have an escalating request starting out in fiscal year 1973 with a total of $46 million, but rising to $68 million by fiscal year 1971.

The distribution as I mentioned is somewhat different. We put more stress on research and professional education funds than has been the case in the bills that are currently up for consideration, because we feel it is here that the long-term solution of the problem lies. We are fearful that if we continue to put all of our funds into the operating programs, we will continue to go through the cycles of mounting extensive and effective campaigns which bring the diseases under relative control to the point that public apathy sets in, appropriations fall off and the VD control apparatus is pretty much ruined, to be followed once again with an increase in the rates.

I don't want to go into great detail. I think that we do have the materials before you for the record, and unless you have further questions on these figures, I will stop here.

Senator DOMINICK. We will include as part of our file, receive and approve, your report from the National Commission on Venereal Disease, the complete report on today's VD control, which you have submitted, I believe, already.

In the interest of the record itself we can keep this in our files, so we don't have too long a record, but it will be available for the subcommittee and the staff.

I have some questions here on behalf of Senator Kennedy. The first one is: Why has the venereal disease problem increased to the present dimensions when under relatively good control in the late 1950's and even in the last decade?

Dr. HUME. Undoubtedly, the changing customs among our population and particularly the youth has played a part, and also the removal of fear of VD as the result of the great reliance on drugs to cure the disease though we know that that is a somewhat misplaced faith for some individuals. Also the fear of pregnancy has become less acute. We think that all of these do play a part.

The main problem, however, is the one to which I referred before, and this is common to all disease control efforts that are dependent upon case finding and treatment and health education. As the number of cases diminish and fear of the consequences of exposure lessens, there is a decrease in our efforts to control them and funds and human resources are not addressed to the problem.

In venereal disease there was a period of public apathy, which was followed by lower appropriations at the Federal and State levels, and a falling apart of the venereal disease control apparatus. As was said earlier, there are still no immunizing agents available. Unless such tools are available to us, it seems unlikely that we will have a long-range solution to this problem.

Senator DOMINICK. The second question is, Will the present methods work? In other words, if funds are appropriated, what can we expect to happen with the venereal disease problem?

Dr. HUME. I think it has been well demonstrated that nationwide coordinated efforts using the methods now available to us can reduce the incidence and prevalence of these diseases. Undoubtedly the reestablishment of a vigorous campaign can once again reduce the incidence of the venereal disease. However, going back once again, the real permanent results can only come about through a better understanding of the biology of the micro-organisms that are involved and the development and application of immunizing agents, and/or perhaps through a better knowledge of human behavior and how to modify it.

This is why the commission did feel it was important to take steps to reinitiate intensive research activities in this field and seek long term solutions while applying the present knowledge to the fullest extent possible.

Senator DOMINICK. Will these bills that we have before us, S. 3342 or S. 3187, accomplish these results?

Dr. HUME. It is true that either bill would be helpful. I think the major problem with S. 3442 is that there are no specifically earmarked funds for any one of the programs and we are talking about venereal disease, tuberculosis, rubella, or what not. It is quite possible that some of the elements will not be funded adequately or, indeed, at all. It

is not clear that all of the essential elements of the venereal disease program could be readily funded.

That including the operational programs through either formula or project grants or both, research, public and professional education, the Federal Government research efforts in VD at the VDRL which apparently is being eliminated——

Senator DOMINICK. Off the record.

(Discussion off the record).

Dr. HUME. It would not provide adequate funds for the Government both in research and the overseeing of the operational program. There are no state plans required at present, no minimum standards set. Dr. Kimmey has pointed out the problem of State plans, on the other hand, it has always seemed to me that when Federal funds are being used, it is quite reasonable to expect that the Federal Government set minimum standards, and that at least some plan be submitted to support use of these funds. They could perfectly well be a part of the broad overall plan.

There is no requirement in the bill that funds supplement and not replace the present funds that are being used.

Senator DOMINICK. Why can't we do the same thing through the comprehensive health planning or the partnership in health organization?

Dr. HUME. My feeling is that when this legislation came along, most of the peolple in the health field, whether you are talking about the State health officers or educators or others, felt this was a very fine idea, and I think it is, in theory, the best approach to the long-range solution of our health programs.

On the other hand, there are some things that are fine in theory, but when it comes to the application there is such a complicated and cumbersome mechanism that it does not seem to meet the national needs.

I am somewhat less optimistic than Dr. Kimmey that in a period of a few years, better solutions can be found through a comprehensive health planning program. I think the authorities are there in the bill, and in theory it should be possible to do all these things, but in actuality you want something done, if you have a big problem confronting you, if you are really going to achieve your goal, you had better have someone who is responsible for it, and you had better have funds specifically earmarked for it.

I think the more understandable the program is, the more apt it is to be adequately funded and administered, and that it will be easier for the administrative and legislative branches of government to oversee it.

Senator DOMINICK. Senator Kennedy may submit additional questions to you in writing. We will keep the record open so we can get your response before us.

On my own, I would like to ask just a couple of questions if I may. One of the provisions in this bill for venereal disease prevention control, of which I am a cosponsor, provides that the allotment to the States shall be based on "the incidence of venereal disease in and the population of the respective States."

What in the world are we using a population figure in there for? Isn't it just incidence that we are concerned with?

Perhaps in the educational field, we might need it, but not in prevention.

Dr. HUME. In the first venereal disease control act that was passed in the 1930's, the LaFollette-Bullwinkle bill, there was a formula set up similar to the one proposed in the current bill that was introduced by Senator Javits and cosponsored by you and others.

It was generally felt that every State did have a problem, that there was a need for some basic formula whereby funds would be channeled into each of the states, and perhaps that was best done on the basis of population.

The more people you have in your State, presumably, the greater the need for an organization to keep up with it and cope with it.

But there was an additional amount that was based on the size of the problem, and that was the major component of the formula. I have no special brief for the population base.

Senator DOMINICK. It would seem to me that you could have an effective State program at this point in a State with a large population and a low incidence, and yet they would get a lot of funds which might be better used somewhere else.

Dr. HUME. One of the real difficulties, not only in VD but any of the communicable diseases, is that as the incidence and prevalence falls it really costs you almost more to do that last bit of work than it does the first bit.

You spend more, and it takes more hours of work on the part of an investigator to locate a case in areas of low incidence than it does in high. So there is a real need to maintain your venereal disease control agency or organization, even though the number of cases is falling.

Senator DOMINICK. That would be true regardless of the size of the population in any State, wouldn't it?

Dr. HUME. Yes.

Senator DOMINICK. I can see why we would need to put more money into a large population State insofar as education is concerned and a study of the reasons and effects and so on for VD or, for that matter, any of these other programs, but for the life of me I can't see why we should use that as a basis for prevention or control.

I put that in for my own purposes to say that I will probably try to do something about that before we are through.

Do you agree with what I understood to be Dr. DuVal's statement, that with 28½ million funding for fiscal year 1973, that gonorrhea and syphilis can be brought under control within 1½ to 2 years?

Dr. HUME. I think you would have to define, or he would, what he means by "under control."

I think that if indeed you mean by control really getting down to some acceptable minimum incidence, it is unlikely that this will happen, no matter which of the bills are passed or how the program is funded, within a year and a half.

On the other hand, I personally believe that the funding that is proposed at the moment is inadequate, and I think that there need to be appropriations, not authorizations, in support of programs at the level of perhaps $45 to $46 million for fiscal year 1973 if we are to begin to mount a successful campaign covering all of the elements of the program including research and professional education.

Senator DOMINICK. I misstated my question. I think what he said on page 10 was that the President requested $24.8 million, not $28.5 as I said. The project grant fund is what I am talking about. That will reestablish the downward trend in syphilis and start to bring gonorrhea under control.

Then I understood him in the process of his presentation that he was talking about doing it rather rapidly, in 1½ to 2 years.

Dr. HUME. I think if all of the funds are put into current operational programs it is probable that the amount of funds could make an appreciable dent in the actual problems of the moment, but this is a short-term approach, and if you are looking for long-term solutions, it seems to me that one must add to this adequate funds which will perhaps lead to the development of effective immunizing agents against these diseases.

Senator DOMINICK. Thank you, Mr. Chairman. That is all I have.

(At this point Senator Schweiker assumed the Chair.)

Senator SCHWEIKER. I would like to ask a couple of questions, Dr. Webster. In one of the statements you say that a survey was made, a finding of which was that 80 percent of the cases of venereal disease were treated by private practicing physicians and that of these they reported only 10 percent.

If I understand your percentages, you are saying that 80 percent and 10 percent are of the same sample?

Dr. WEBSTER. No, the statement was sent to all physicians in the United States. We had a very good response. It developed then that 80 percent of the cases of venereal disease were treated by private physicians in their offices. They reported to health authorities only 10 or 12 percent of such cases.

Senator SCHWEIKER. You mean they reported only 10 percent of the 80 percent?

Dr. WEBSTER. Yes; the rest were not reported.

Senator SCHWEIKER. Why was that?

Dr. WEBSTER. The doctors are trying to protect the patient, particularly in smaller communities. This is something the center for disease control has been working on for some time. It is a difficult problem. I think the education of the physician into these responsibilities is a very important factor and it is something we have included in the Commission report.

Senator SCHWEIKER. What reporting is required, and reported to whom?

Dr. WEBSTER. To the local city or State health department. I think that is required in every State, is it not, Dr. Hume?

Dr. HUME. Yes.

Senator SCHWEIKER. In other words, it is required in every State by law.

Senator DOMINICK. What happens to the private physician-patient relationship on something of that kind?

The patient does not want the world at large to know that he has a disease which is socially unacceptable at least.

Dr. WEBSTER. I think that is one of the problems here, that the physician is protecting the patient.

Senator DOMINICK. Isn't it a violation of ethics if the doctor wants to report it and the patient does not want him to?

Dr. HUME. It is a violation no matter which way the doctor moves.

Senator SCHWEIKER. Is it a matter of giving names, places, and dates, or can they report they treated a certain kind of venereal disease?

Dr. WEBSTER. They must report the name and address of the patient, then an investigator for the city or State health department approaches, first the doctor, getting his consent, and then the patient. That is the basis of our epidemiological procedure in this country today.

Other countries use different methods.

Senator SCHWEIKER. I think you brought up a very important point here and I would like to pursue it. I think the question becomes, should our national objective be in a case like this, to get people to come forth and see their doctors and get treated, or should the objective be to have people report it so that it can be followed up for medical reasons.

In your judgment, which is more important? It seems to me there is a conflict in terms of the two alternatives, and I think one of the questions the committee ought to address itself to is this very point. Which is the more important priority, in your judgment?

Dr. WEBSTER. Historically there is an interesting factor that has a bearing on this. Many years ago the treatment of gonorrhea and syphilis was complicated. A private doctor could not do it in his office.

Therefore, we had large public health clinics throughout the country. With the advent of penicillin, treatment became simple, and anybody could do it. Therefore, there was some switch over. This has happen in other countries, too. As Dr. Sencer has said, we feel strongly that the strengthening of our public clinics is important. Those cases are going to be reported if they go there. There is no question about it. If we could increase the numbers of these facilities, and make them more attractive, I think we would play a big role in this.

Senator SCHWEIKER. It reminds me of the drug problem in Vietnam and the question of amnesty. I wonder what our national objective ought to be. I think this is important.

If we want to treat the people who are sick, it seems to me we have to establish some traditional doctor-patient relationship in a way that people will come forth and be identifiable, on a confidential basis. I think really this is the crux of it. I think your own survey showed that private doctors treated 80 percent of the cases. Only 10 percent are reported. When you see that kind of slippage or gap between what the doctor does and what gets reported, you wonder how far bigger a gap there is between the people who don't come to the doctor in the first place for the same reason.

I think it is a very important problem in this situation.

Dr. HUME. This has been a very important and very difficult problem to cope with over the years. It is quite natural, I think, that the physician will wish to protect the patient and the confidentiality of the relationship. By the same token, it is true that this individual has gotten his disease from somebody, and he is going to spread it to others and there is the dilemma.

It has been felt that in order to protect the health of the public there is a greater need, perhaps, for the reporting of these diseases and in order that this epidemic can be stopped.

Now the fact that the doctor reports the case, even if he reports it by name, does not actually defeat the confidentiality of the material; in other words, it is not put in the newspaper. It is given to people who themselves are professional people, and it is only quite rarely that inadvertently word gets out, it does, however, allow the investigator to interview the patient to determine to whom he may have given the disease and from whom he may have acquired it.

When those people are tracked down and brought in for examination and found infected, they, too, are interviewed and treated.

Senator SCHWEIKER. When are cases reported to the central health authority? When one is, are you describing the followup that occurs?

Dr. HUME. Yes, sir; the State health department, or more often the local health department, gets in touch with a physician, states that an investigator will be interviewing the patient, and asks how the physician would like this to be done? He can meet him at his office or he can go to the home.

This is worked out with the physicians. Now in any procedure such as this, there are obviously times when, unfortunately, things go amiss, but, in terms of loss of confidence and confidentiality, these are very, very rare in proportion to the total number of investigations carried out.

(At this point Senator Hughes assumed the Chair.)

Senator SCHWEIKER. With a new way of treating venereal diseases today, is there much information required from the private physicians treating them?

In other words, as Dr. Webster described, is there an advantage today to all the followup, although initially there was a lot of good reason for such followup? If a patient comes to a private doctor and gets whatever the penicillin treatment is, is there an added advantage of any significance, for the followup to occur through the State health authority today as compared to before? Or does the doctor normally follow up on his own privately?

Dr. HUME. Unfortunately, the latter course does not mean to work well, except with a very limited number of physicians. It is very interesting that the venereal disease patient, while he relates well to the physician in terms of his treatment, he does not seem to relate well in terms of giving out information on the sources of the disease or the individuals to whom he may have spread it.

I am sure that there are some psychological explanations for it, but I don't personally know them.

Also, there are good many people that do not come for treatment to physicians, and there is a great, great number of people who have venereal diseases who do not seek treatment from any source until they are sought out.

Senator SCHWEIKER. What I am trying to ask is, if we had to choose between getting people to go to physicians to get treatment, or knowing and following up with those who did go and get treatment, which would be more important in this country's health posture?

Dr. HUME. I believe the public health physicians as a group and the public health authorities of all professions would certainly feel that there are more advantages to actually requiring the reporting and the pursuing of the type of epidemiological investigations that have been pursued quite effectively now for the last 30-odd years.

Senator SCHWEIKER. But suppose x percentage of the people don't bother to get treated. From your 80–10 percent example I think there is a tipoff. This is what the psychology is, and this is what the drug amnesty problem was. I have a case right now where a young fellow has a drug problem and the last people he wants to know about it are his parents.

He does not want to get treated in any way. I can't help but believe that he is exactly the same kind of situation you have here. People don't even want to get tested to find out if they have something if their parents are going to find out about it. Isn't that the guts of the problem here, too?

Dr. HUME. I think it is a little different than drugs, because there is not any crime associated with venereal disease, and no penalties, but I do believe that there are many people who do not seek treatment, not because they are worried about the social stigma at all, but they are either ill-informed or indifferent to the complications which potentially come from the diseases.

Senator SCHWEIKER. If that is true, then your own figures don't agree with that, because you said that only 10 percent of the 80 percent went on to do that.

So there are 70 percent of the cases that are not going through because of a social stigma or something, unless I am misunderstanding either your facts or what you are telling me.

Dr. HUME. Of the patients who come to treatment, presumably 80 percent go to private physicians. That is a very rough estimate. Of those 80 percent that go to the physicians only the small percent, 10 or 12 percent, or 15 percent, are reported by the physicians.

Now there are more of those that are not reported by the physicians, not at the request of the patient, but just because the physician either does not think it is important, or in some instances because he is very fearful of somehow or other abrogating his responsibility to the patient.

Senator SCHWEIKER. When you say a physician does not think it is important. It is the law, if you are telling me correctly. It is the law of each State now. It could not be a matter of not thinking it is important.

Dr. HUME. This law has never been enforced, not only in venereal diseases but in most diseases. Doctors have not been brought to court and prosecuted for lack of reporting. There has been an effort to use this as an educational device and an effort to try to convince the physician that this is his public responsibility, and that it is worthwhile, and there are some very remarkably fine examples of where a good relationship has been worked out.

There is a county in Michigan where the county society and the health authority got together on a program and there they got 100 percent reporting, and the rates did go down dramatically. So that where it can be worked out, it works out for the welfare of the community without any question.

Senator SCHWEIKER. I remember seeing a TV documentary on venereal disease and cameras actually went into the VD treatment center, and 90 percent of the patients turned their faces from the camera. I don't blame them, and that is the problem you are dealing with.

How many people want to volunteer their name in this kind of a situation? Isn't that really your greatest problem of treatment? If it

is—and I presume it is—then it seems to me that maybe some of the laws and approaches are obsolete in really dealing with the problem.

I don't want to prolong it, and I realize it is sort of conjecture as to what we are talking about. I suspect it depends on each individual person as well as each doctor, but it seems to me there is quite a problem in this regard.

Dr. WEBSTER. One recommendation of the commission was that we look into the whole matter of the present approach, compare it to what is being done in other countries and compare it.

Senator SCHWEIKER. I think we should. I agree. I think it is sort of a tip of the iceberg kind of thing and I think we have to understand why.

That is all, Mr. Chairman.

Senator DOMINICK. Mr. Chairman, I have a couple more questions. We have had information come to our office that the women who have venereal disease, a very substantial proportion have no symptoms which are visible to them. Under this particular bill, if that is true—is that true?

Dr. HUME. Yes.

Dr. WEBSTER. Yes.

Senator DOMINICK. Under this bill, there are grants to diagnostic centers for VD. It occurred to me that it might be better to try and get back at this problem by simply including a big diagnostic technique in any kind of clinic in which persons come in for an ordinary health checkup. What do you think about that?

Dr. WEBSTER. Dr. Sencer covered that in his earlier statement. I think this is the intention, to set up a massive screening technique, where women go for examination, birth control information, and this type of thing.

This is part of the program for next year for the Center for Disease Control.

Senator DOMINICK. Thank you.

Senator HUGHES. Thank you very much, gentlemen, for your testimony.

(The prepared statement of Dr. Webster, with attachments, follows:)

STATEMENT

BY

Bruce Webster, M.D.

Chairman, National Commission
on the Venereal Diseases

Clinical Professor of Medicine
Cornell University Medical College

President, American Social Health Association

It has been estimated that there were 2 1/2 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.

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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 Neruology. 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 then 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 availavle 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 and 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 motovations 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.

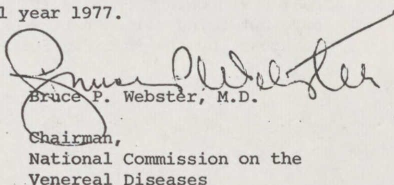
In the light of the extensive communication between both HEW and the component groups themselves which has resulted from meetings of the National Commission, it is strongly recommended that a Advisory Council on Venereal Disease with appropriate governmental and nongovernmental membership be established 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.



Bruce P. Webster, M.D.

Chairman,
National Commission on the
Venereal Diseases

CONCLUDING OBSERVATIONS

Our concluding observations with reference to S. 3442 and S. 3187 are:

1. Passage of the Communicable Disease Control Amendments Act of 1972, S. 3442, 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 financial support levels.

2. Passage of an even more specifically earmarked National Venereal Disease Prevention and Control Act, such as S. 3187, 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, as set out in S. 3187, should be revised to coincide with the expert recommendations from both the private and government medical sectors, which were released only last week. 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 being mailed next week to each member of the Senate and House, by the American Social Health Association.

REPORT

of the

NATIONAL COMMISSION ON VENEREAL DISEASE

to the

Assistant Secretary for Health and Scientific Affairs

Department of Health, Education, and Welfare

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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.

DR. BRUCE WEBSTER
[illegible]
NEW YORK 21, 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. 20201

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.

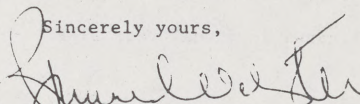
Viewed in the perspective of 65 years since the discovery of the etiological agent of syphilis, much has been learned about the venereal diseases through experimentation, clinical observation and epidemiological research. Yet, despite potent additions to our therapeutic weapons, both syphilis and gonorrhea 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 continuted 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 of the National Commission on Venereal Disease

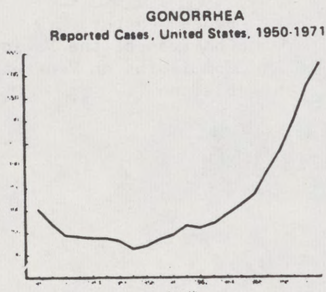
FOREWORD

The Commission is deeply concerned over a number of findings:

(1) the alarming increase of reported venereal disease;

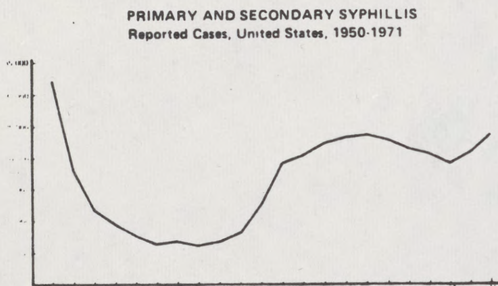
The Commission noted that reported cases of gonorrhea, following a decline in the early 1950's, has shown a steady rise from 216,476 cases in fiscal year 1957 to an all time high of 624,371 cases in fiscal year 1971.

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;

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(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

	Fiscal Year (Dollars in Thousands)					
	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

* Details of recommended budget, pages 46, 47, 48 and 50.

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 present time, States and localities are primarily responsible for the diagnosis and treatment of people with venereal 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 non-pathogenic 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 microbiologically 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 syphilis 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 syphilis. 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 control 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 syphilis 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 behavioral 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 venereal 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

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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, teaching 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 genito-infectious 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 diseases 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 word 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 essential 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 bacterial 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 civic 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 venereal 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 fulltime director to produce educational materials and to assist professional organizations develop educational programs.

Comment:

Such a 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 venereal 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 venereal 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 venereal 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 venereal 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 be 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 positive 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 of 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 opportunity 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 venereal 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 venereal 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 than 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.

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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 concern 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 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 responsibility 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 education 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 (attached)

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 (attached)

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 (attached)

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	22,300 (1)	25,000	28,000	30,000	30,000	30,000
VD Branch Operating Funds						
a) Administration, technical assistance, on-going 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) FY 1972 appropriations under Section 314(e) and 317 of PHS Act.
(2) VD control demonstration contracts.
(3) VD line item of Communicable Disease appropriation.

TABLE II

Recommended DHEW Funding Levels

New Venereal Disease Research

	Fiscal Year (Dollars in Thousands)				
	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	2,000	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.

TABLE III

Recommended DHEW Funding Levels

Venereal Disease Professional Education

	Fiscal Year (Dollars in Thousands)				
	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
TOTAL PROFESSIONAL EDUCATION	4,200	4,485	4,700	4,920	5,235

4. The Commission recommends that for all elements of the venereal 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 (attached)

TABLE IV

Recommended DHEW Funding Levels

All Venereal Disease Program Areas
(Summary)

	Fiscal Year (Dollars in Thousands)					
	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

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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 syphilis 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 had 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 secondary 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 Appropriation 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 venereal 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, venereal 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 casefinding 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 Clinical Medicine
Cornell University Medical College
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New York, New York 10021

Representing: The American Social Health Association

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Harry Pariser, M.D. Director, Venereal Disease Control Norfolk City Health Department 401 Colley Avenue Norfolk, Virginia 23507	American Venereal Disease Association
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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

APPENDIX III

Graphs and Charts

1. Communicable Diseases - Number of Reported Cases

   United States - Calendar Year 1970

2. Reported Syphilis and Gonorrhea Cases

   Per 100,000 Population (All Areas Reporting in the Continental United States)

3. Syphilis, Reported Cases by Diagnosis

   United States, 1941-1971

4. Gonorrhea Screening Summary (Females)

   Percent Positive by Type of Facility Performing Test

   FY 1970

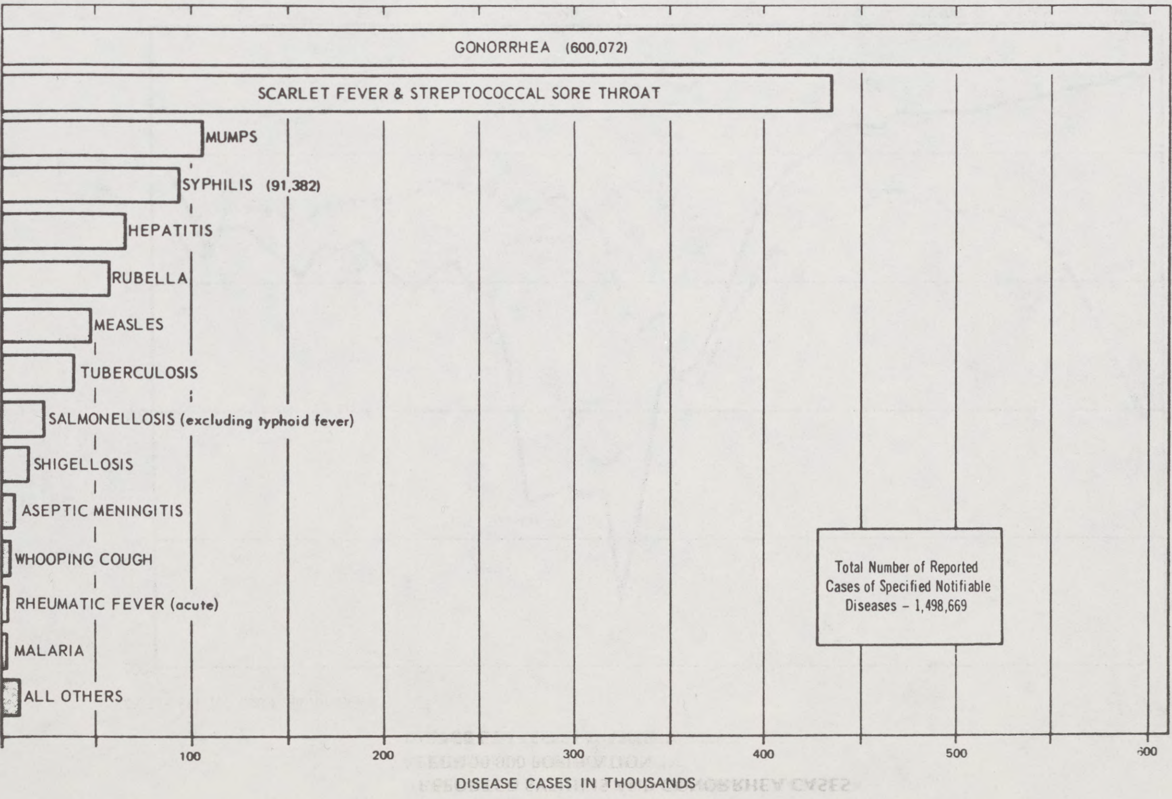
5. Gonorrhea - Geographic Distribution

6. Primary and Secondary Syphilis - Geographic Distribution

7. States not Permitting Examination and Treatment of Minors Without Parental Consent

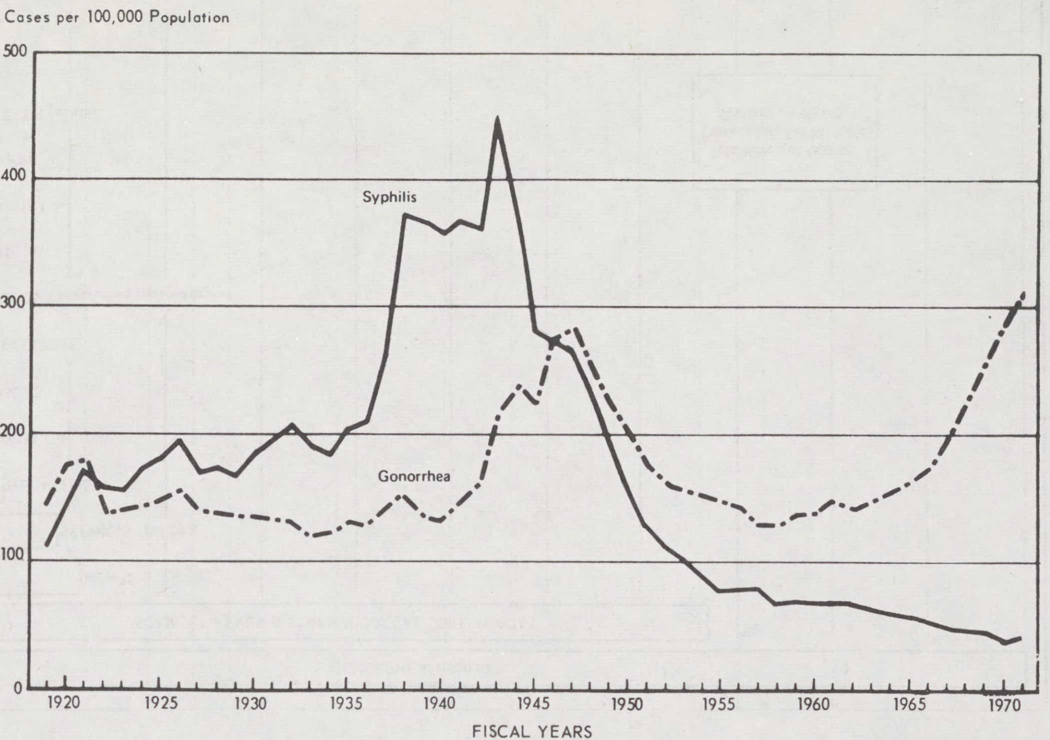
8-10. Reporting Practices in States

COMMUNICABLE DISEASES – NUMBER OF REPORTED CASES
United States, Calendar Year 1970

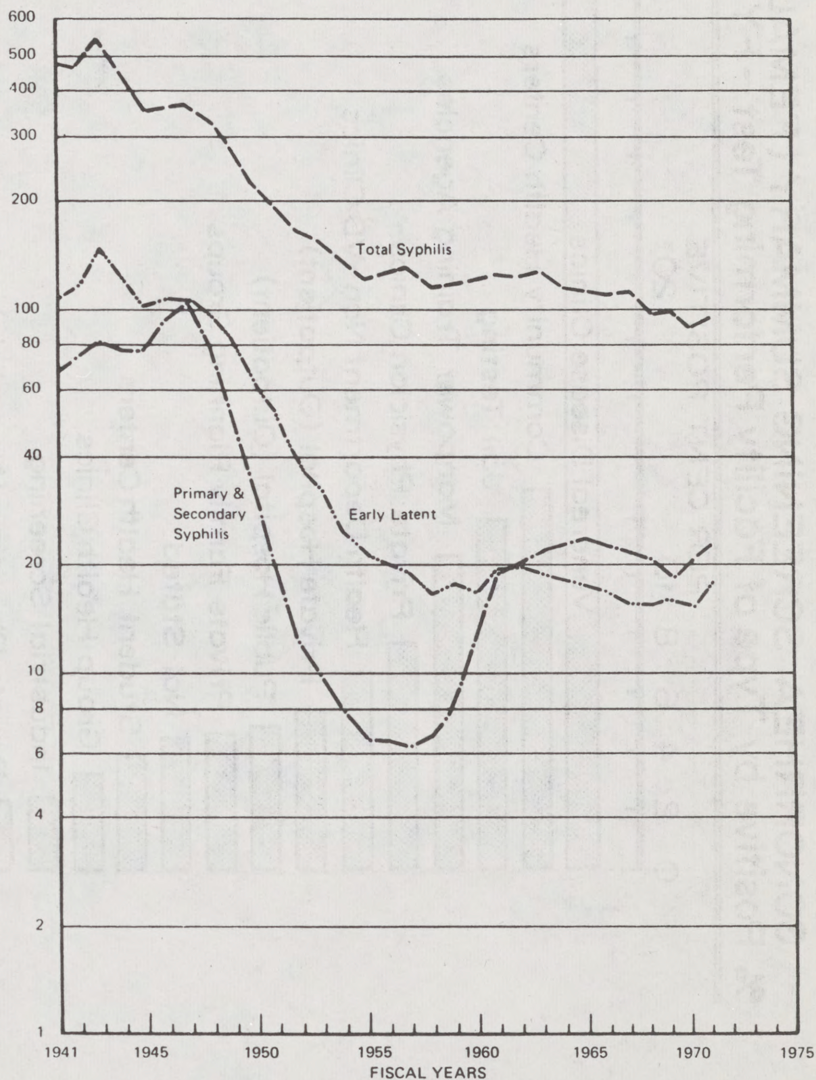


1.

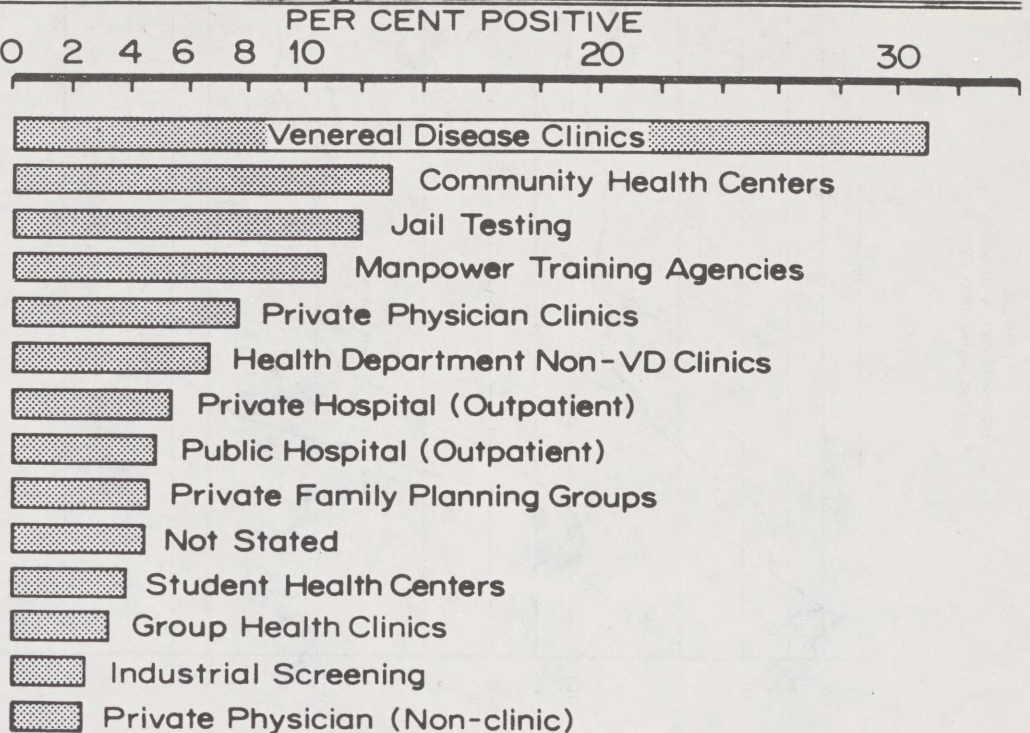
REPORTED SYPHILIS AND GONORRHEA CASES
PER 100,000 POPULATION
UNITED STATES*, 1919-1971



*Beginning in 1939 all states are included in the reporting area
(Military cases included 1919-1940) excluded thereafter)



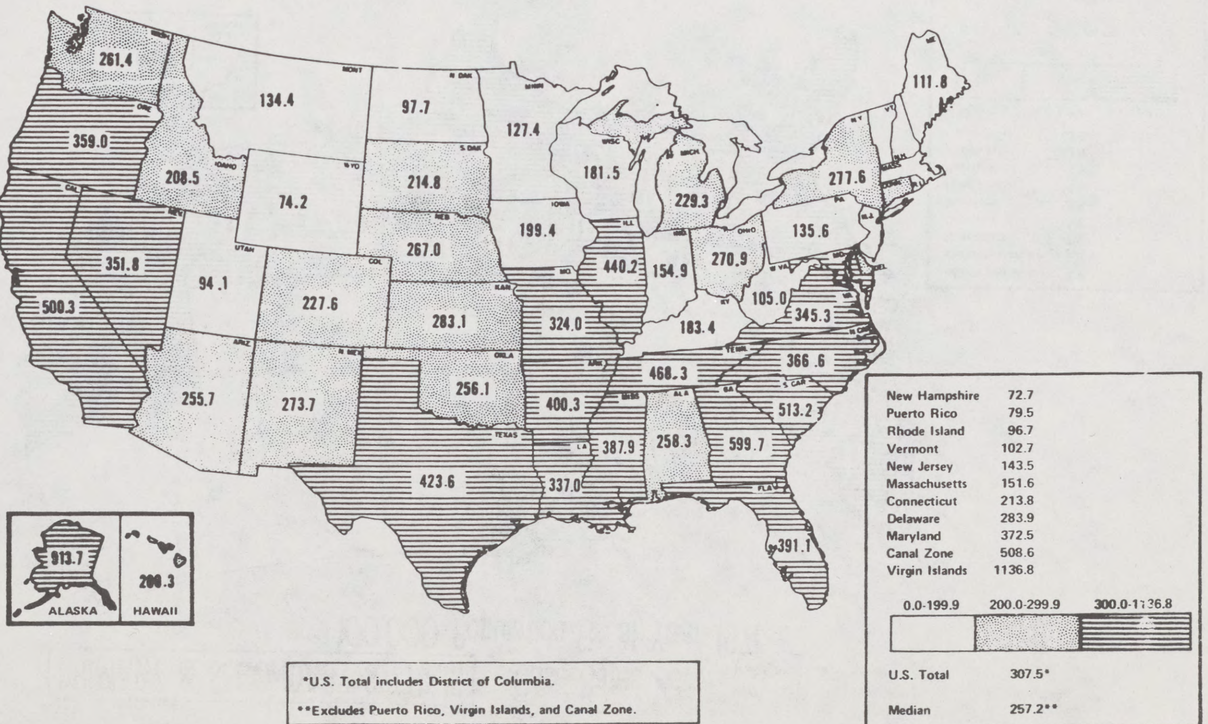
3.



4.

GONORRHEA

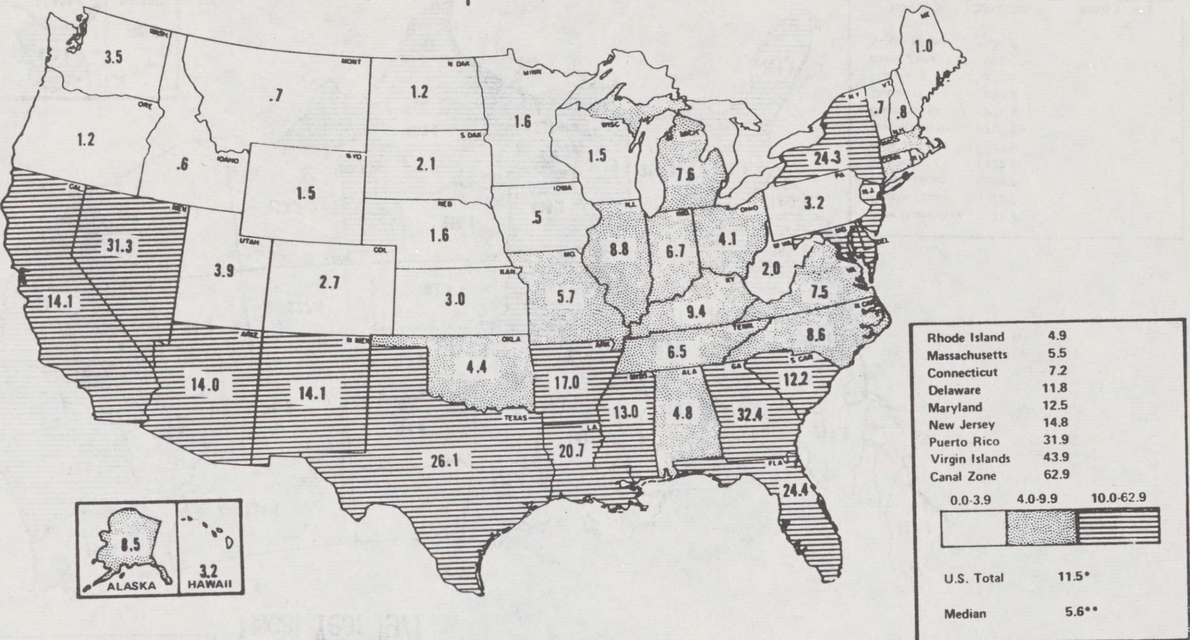
Case Rates per 100,000 Population
Fiscal Year 1971



*U.S. Total includes District of Columbia.

**Excludes Puerto Rico, Virgin Islands, and Canal Zone.

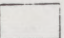
PRIMARY & SECONDARY SYPHILIS Case Rates per 100,000 Population-Fiscal Year 1971

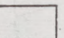


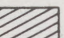
*U.S. Total includes District of Columbia.

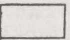
**Excludes Puerto Rico, Virgin Islands, and Canal Zone.

STATES AND TERRITORIES WHICH DO NOT PERMIT EXAMINATION AND TREATMENT OF MINORS WITHOUT PARENTAL CONSENT
JANUARY 1, 1972

 Alaska

 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

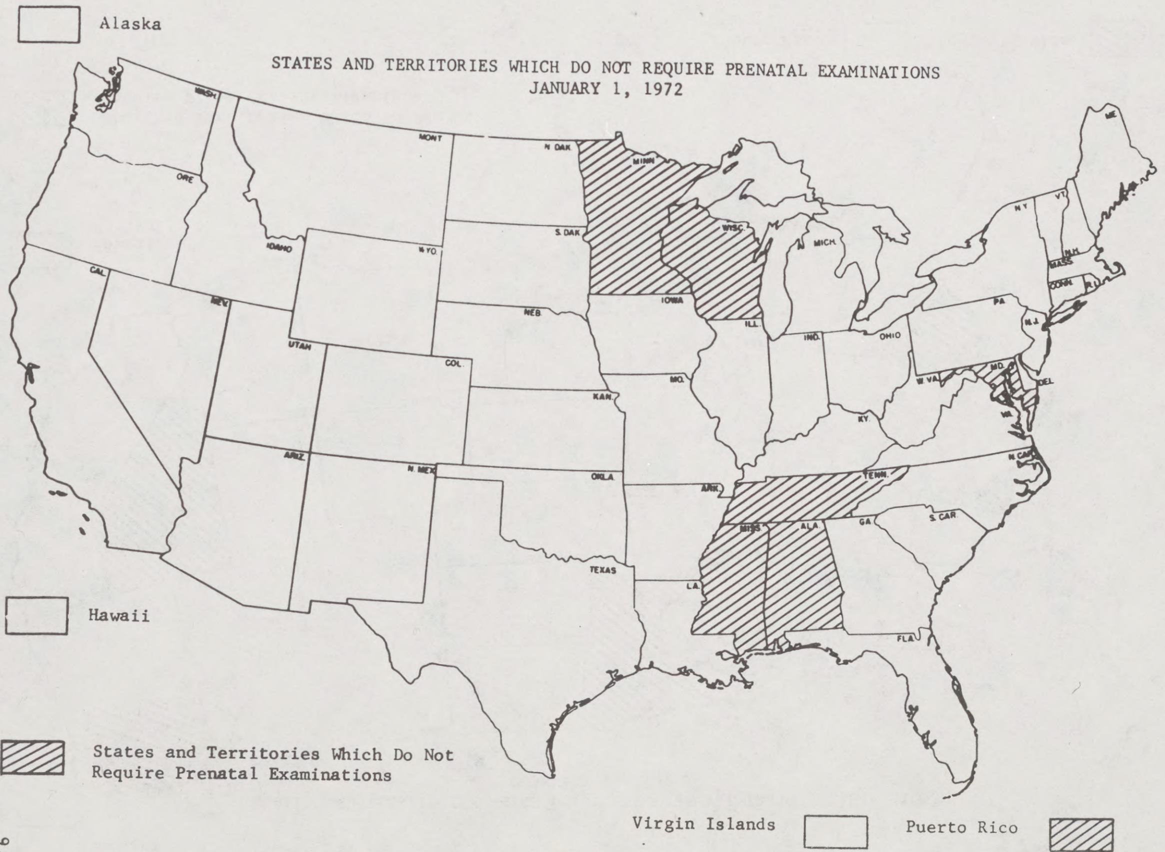
Hawaii

States Which Do Not Require
All Laboratories To Report
Reactive Tests

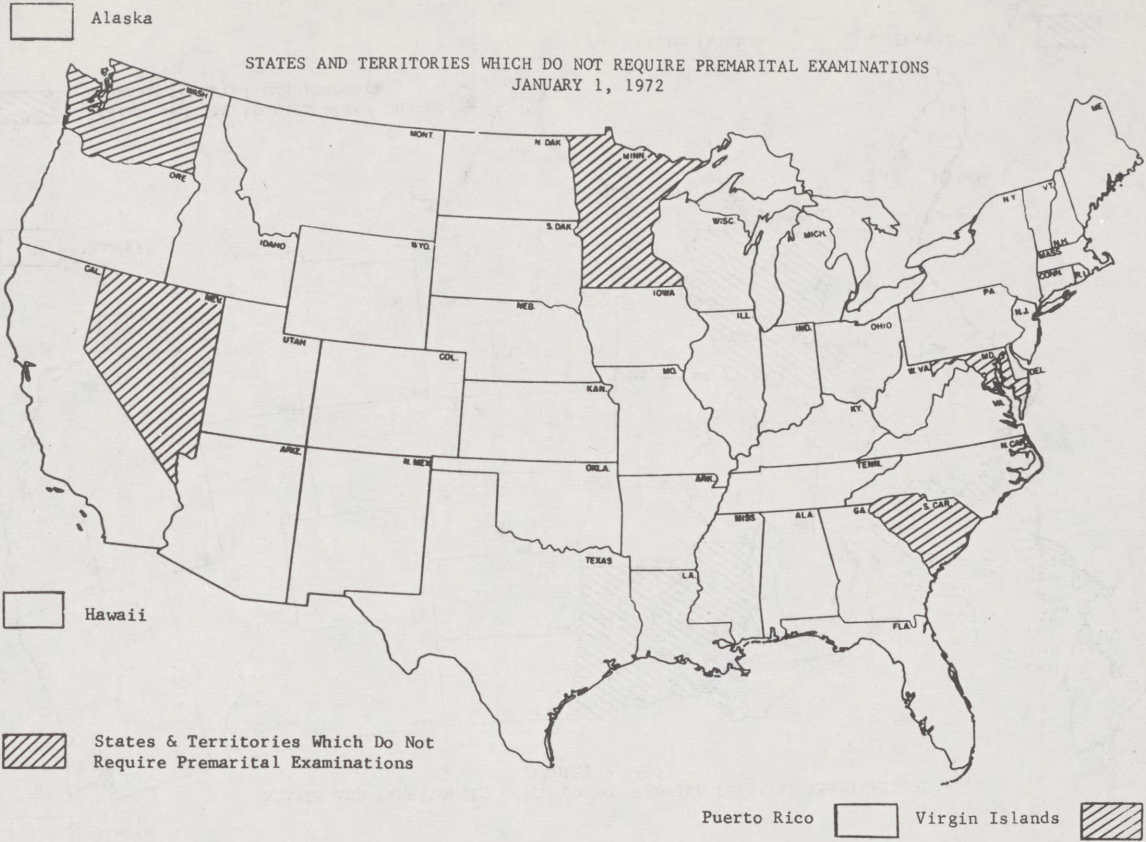
Virgin Islands

Puerto Rico

STATES AND TERRITORIES WHICH DO NOT REQUIRE PRENATAL EXAMINATIONS
JANUARY 1, 1972



STATES AND TERRITORIES WHICH DO NOT REQUIRE PREMARITAL EXAMINATIONS
JANUARY 1, 1972



Senator HUGHES. The Chair calls Dr. Robert Parrott, chairman of the Department of Pediatrics, Childrens Hospital, Washington, D.C. Dr. Parrott is a member of the Committee on Infectious Diseases. He is here today representing the academy. Dr. Parrott, you may proceed with your testimony.

STATEMENT OF ROBERT H. PARROTT, M.D., AMERICAN ACADEMY OF PEDIATRICS

Dr. 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 S. 3442 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 Amendments Act of 1972 and believes that specific authority and funding should be provided for these purposes in a continuous way, which would allow for program development that would lead to eradication of these diseases.

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

Our concern and frustration are that we know medically what can be, one in the instances 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 massive 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; 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, 505,000 days of hospitalization were avoided and 32 million days of absence from school averted. It is estimated that this was worth $423 million.

Continued strong support which is earmarked for these purposes 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, or in similar haystacks in the various States.

Funds, in fact, have been reduced under previous authority. We ask renewed special attention to immunization on programs and fuller funding for these programs.

We also direct our concern specifically to the need for the designation of similar authority in S. 3442 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 1970's.

The facts are indeed frightening. It is estimated that there will be 600,000 reported cases of gonorrhea in 1 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 so-called 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 S. 3442—or, if necessary, in a separate bill such as S. 3187—We must: (1) open our eyes to the fact that gonorrhea and syphilis exist up and down the street from each of us; and (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 our society are freer. There is little thought to the consequences.

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.

Senator HUGHES. Parrott, thank you for your statement. Could you tell us why we cannot just rely on existing 314 authority?

Dr. PARROTT. In our view, these are special problems, particular problems, and under the 314 authority they will be lost in the shuffle.

They have been in the past in the proposed appropriations. For the upcoming year—not what I have heard this morning—but from what I had understood, there was a reduction in funding for these programs. I think I did hear Mr. DuVal this morning speak of revising the appropriations request.

Senator HUGHES. As you put it in your statement, you feel they would just be lost in the haystack of bureaucracy.

Dr. PARROTT. Yes, sir. I think there is another reason for a special act, which is to call public attention to the problems, both the prob-

lem of those diseases which can be eradicated by vaccination and the VD problem.

I think a special act is more likely to lead to special public attention and special public education than programs which are carried out through 314 authority.

Senator HUGHES. You mentioned 600,000 reported cases of gonorrhea. Do you have any way to make an estimate of what you feel the accurate figures would be?

Dr. PARROTT. I suppose you could extrapolate from the figures that were just given a minute ago, but it is said that it is at least six times that by some authorities.

The problem is very much wrapped up in what was being discussed a moment ago. I think, particularly for young people, the reported incidence is much lower than what actually goes on.

Senator HUGHES. Senator Dominick.

Senator DOMINICK. Thank you.

Doctor, I will be very brief. One, there is a provision in the venereal disease bill for a separate State plan. Do you see any need for a separate State plan, or could it not be included in the comprehensive health plan?

Dr. PARROTT. I think there could be similar advantages in having separate State plans, as there are advantages in having separate Federal legislation, that is, earmarking, calling public attention and local government attention to the problem.

However, Senator, I am not familiar enough personally with how State plans are developed to be able to comment further on that.

Senator DOMINICK. Most State plans, unless they have been brought in and approved, are stacked away in a warehouse somewhere, and no one ever sees them again.

It strikes me if we had a comprehensive health plan, which we do in most States, we could just include this as part of that, so you would not have to go through the extra paper work.

Do you see any objection to that really?

Dr. PARROTT. No, not the way you put it.

Senator DOMINICK. Secondly, do you have any comment—and maybe this was what the chairman was referring to—on this problem of the physician-patient privilege insofar as followup is concerned on venereal disease problems?

Dr. PARROTT. You should know that this is a very peculiar problem for those who deal with children. Legally, a physician or a health service has been required to have parent's permission in carrying out any kind of treatment for a minor, for an individual under 21.

To take the case of gonorrhea, about 20 percent of the gonorrhea is occurring in individuals under 20. Many young people will not seek treatment lest their parents learn about their problem.

A number of States have introduced either legislation or regulations that eliminate the requirement for a physician or health service to get a parent's permission in the case of venereal disease treatment and in certain other types of treatment.

But it is complex because many feel if one is going to attack the problem in the long run, attack the problem of teenage pregnancy, for example, and work out a program of real advantage to the family and the youngster, that it would be of advantage to get the family involved.

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However, in order to get to the disease, venereal disease, in order to get a girl who is pregnant in early enough to do something about it, one has to, I think, go along with the idea that an individual type of private relationship with a youngster can be introduced, and a physician need not involve the family.

I feel though in overall venereal disease control one can work out a sensitive enough system for confidential reporting—and, as a matter of fact, this has worked out in some of the free clinics with youngsters that involve an informal confidential reporting system wherein youngsters are encouraged to say where they probably got the gonorrhea—and where a sensitive investigator does look into who the contacts were, and tries to get to them, to try to lead them to treatment.

I think there are true advantages that were mentioned earlier of reporting venereal disease for the purposes mentioned, but what may be needed is a much more sensitive approach, much more confidential approach, to handling the problem.

You know a lot of us, I am sure a lot of parents, a lot of physicians, are rather judgmental about the finding of venereal disease. That attitude can be detected by individuals, and by youngsters particularly, and I think we have to begin to look at this as a health problem, which is indeed a part of a social problem, but it is a health problem, in trying to set up mechanisms for handling it more sensitively.

In other words, I think we need reporting. I think we should do it in a more sensitive way.

Senator HUGHES. Dr. Parrott, I might just ask you. Previous witnesses testified to the fact there was no violation of the law involved in this, and no penalties.

Dr. PARROTT. If it was not reported? With failure to report?

Senator HUGHES. With failure to report, but on the matter of enforcing laws, I believe every State in the Union prohibits commission of the sex act outside of wedlock, regardless of age. It must be about the most violated law in America today, unless it is the laws against smoking marihuana.

I am wondering about this. I know in my own State from my experience as Governor that we do have a few people in prison serving sentences as a result of breaking some of these laws, but you have to prosecute both parties; you just cannot prosecute one or the other; it has to be both parties involved.

I suppose the only purpose of this question is: Do you believe we should rid ourselves of all of these extraneous laws that are obviously unenforceable, and which have not been enforced in most States for years?

Dr. PARROTT. Let me comment. The feeling of many individual physicians about communicable disease reporting—and perhaps if my comment is correct it could lead to an approach which would allow us to adhere to the law as it was intended—I think physicians often feel that the requirement to report certain communicable diseases is just a law, and little is done about it, and it becomes cumbersome, and they do not necessarily fully understand it.

The way many physicians have been brought up over the last 20 or 30 years, they have thought that the lectures on epidemiology of venereal disease and control as given by medical school or public health people have been among the driest, the least understandable,

the least important in their interpretation of the various kinds of principles that have been taught.

They have not seen a real followup on a lot of communicable disease reporting.

I think if communicable disease reporting, including VD reporting, can be made simpler, a hot line type of thing, less cumbersome in terms of writing things out, the follow up made more sensitive, then the real value of it, which I do not think could be disputed, could take place.

It may be there would not be so many "law breakers" as there apparently are among physicians.

Senator HUGHES. A few weeks ago I had an opportunity to talk to a man and wife team of physicians, and the wife particularly was directing her energies at educational programs on university campuses in the State of California.

The problem she was running into was that in an educational forum no one would come forth but there were many contacts in the informal atmosphere afterward. Then within a day or two or week afterward she receives requests by phone for advice or examinations.

Do you have any specific recommendations we might consider as a committee to improve education and public information so that this problem can be brought out into the open?

We obviously have an epidemic widely out of proportion to our capabilities of meeting it.

Dr. PARROTT. With regard to the group of diseases for which there are currently vaccines, I think the public information largely needs to be directed to inner city groups, and it is going to require very special attention.

This is a problem that has not been dealt with successfully in the instance of other aspects of health care, so that very intense efforts are going to be necessary by sensitive people, hopefully by people coming from the immediate community.

As a public information and education matter, and with particular regard to venereal disease I think we have to open the minds of parents, and PTA's—there are PTA's in this country who do not think we ought to teach the principles of sex and the potential consequences of disease in the course of sex.

On the other hand, there are examples of very progressive programs in certain PTA's. There are other "crash" programs. There will be one in this city, as I understand it, in the fall, a crash porgram in which I believe it will be possible to call attention to the problem of venereal disease, with an invitation in multiple places—clinics, physicians' offices, whatever—to come and be examined, to be examined for possibility of venereal disease.

I think we need more crash programs. I think we need a long term program of sex and health education, as I implied before, not just for children but for all of our families.

Senator HUGHES. Dr. Parrott, I take it you feel our educational systems are not meeting the challenge of explaining VD and the risks at all.

Dr. PARROTT. Collectively, as families, churches, and school systems, we apparently are not. I do not think it should be put all on the school system by any means.

Senator HUGHES. No, but we are failing in getting that sort of approach across.

Dr. PARROTT. Yes.

Senator HUGHES. Dr. Parrott, thank you very much for your testimony and your willingness to be here.

Our next witness is Dr. Leo Reichman, tuberculosis control officer of the New York City Department of Health.

Dr. Reichman, we welcome you to the subcommittee.

STATEMENT OF LEE B. REICHMAN, M.D.; MPH DIRECTOR, BUREAU OF TUBERCULOSIS, NEW YORK CITY DEPARTMENT OF HEALTH

Dr. REICHMAN. On January 16, 1972, an editorial appeared in the New York Times. I found it quite disturbing and would like to share some of my thoughts about it with you today.

The editorial was basically a salute to the 50th anniversary of the discovery of insulin. To quote the editorial:

> This historic achievement has relevance for medical problems now under intensive discussion. The present tendency is to put into the foreground "practical" questions of the organization and delivery of health care while minimizing basic research in the medical and related sciences.

The final paragraph of the editorial reads:

> Today the unsolved problems of coronary heart disease, neurological illness and other ailments require similar basic discoveries before cures can be found. The insulin story is a useful reminder that too great concentration on the "practical" approach to medical problems with a consequent downgrading of research can be self-defeating.

How, you might ask, does this editorial concern the legislation under consideration, which is communicable disease, specifically, for me, tuberculosis. 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 pathogenisis, 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 "basic discoveries," to use the wording of the editorial, are required "before cures can be found." Yet in 1970, tuberculosis killed 5,560 Americans and newly affected 37,137. Of these, 386 deaths and 2,590 new active cases were New Yorkers. Dr. DuVal pointed out that the rates have come down gratifyingly, but I must point out in nonwhites in the USA the rate was up 2 percent in the period 1969–70. 1969–70.

In other words, this disease in which no more basic research is needed, is still a grave, health, economic, and social problem. Another statistic which I feel brings home the point is that the new active case rate for central Harlem in 1970, although gratifyingly down 50 percent since 1960, was higher than the rate for New York City as a whole was in 1942—135.9 percent per 100,000 population to 130 per 100,000 population.

The preceding remarks, I feel, provide us with compelling evidence that, the editorial notwithstanding, "practical" questions of health care delivery are still a paramount problem in medical practice. Tuberculosis rates, I feel, are a prism through which the glaring deficiencies in the organization and delivery of health care can be viewed.

With this as an introduction, let us look at the tuberculosis problem in New York and what we have done with your aid, but what still must be done.

Tuberculosis occurs among the people of all ethnic backgrounds. Since 1945 marked changes have occurred in the ethnic makeup of New York City. An ethnic analysis of tuberculosis patients compared to the makeup of the city itself reflects this. In 1945, whites represented 90 percent of the population and accounted for 70 percent of the new active tuberculosis cases reported. Nonwhties and Puerto Ricans represented 10 percent of the total population and accounted for 30 percent of the new active cases of tuberculosis. On the other hand, in 1970 whites made up 67 percent of the population and accounted for only 32 percent of the new active cases, while nonwhites and Puerto Ricans represented 33 percent of the population and accounted for 68 percent of the new cases.

Thus we can answer the question who gets tuberculosis by saying that although tuberculosis declined among all ethnic groups, the minority groups in whom dissemination of health care is still a great problem, were most affected.

Where are the new patients? The new active tuberculosis case rate for New York City in 1970 was 32.8 per 100,000 population. This is the average for the city's 30 health districts. The individual district rates range from central Harlem's 135.9 per 100,000 population, to Flushing's 7.2 per 100,000. Only eight of the 30 health districts, with a total of 1,348 new active cases account for 52 percent of the new active cases reported in the entire city.

Underscoring these figures is the fact that the city's rate is twice the national rate of 18.3 per 100,000 and three times the upstate New York rate of 11.9 per 100,000.

To further emphasize where the new patients are: the rate in central Harlem is seven times the national rate and 11 times the upstate rate.

One more representation which most effectively shows us where the new cases are, is this comparison of the per capita homicide rate for each district, compared with the geographical distribution of tuberculosis cases. It can be seen that they are almost identical in distribution.

Most of our cases are reported from hospital and department of health chest clinics. Only 4 percent of the new active cases were reported by private physicians. This reflects again the health care delivery pattern in our city as far as the average tuberculosis patient is concerned. TB patients, almost by definition do not have access to private health care delivery.

In 1963, the Surgeon General appointed a task force to study the status of tuberculosis control in the country. This report 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 means of increased formula and project grants to the States. New York City, acknowledged as having the greatest tuberculosis problem, was a charter recipient of this support. I would like to review for a moment what was done in New York City with the substantial personnel, funds, and flexibility, provided by the Federal tuberculosis project.

The tuberculosis project, which is under the control of the director of the bureau of tuberculosis, provides support in the form of managerial

expertise, administrative service, personnel, supplies, and equipment to augment and sharpen New York City's tuberculosis effort. Project funds and personnel are not used to offset city tuberculosis expenditures, nor is the project scheduled within the city budget.

Therein, the project possesses the ability to quickly readjust its support and line item budget in accordance within the problems at hand. This flexibility had provided the project with major impact which is demonstrated in the following program activities.

Combined chest clinics are located at Bellevue, Coney Island, Harlem, Lincoln, Kings County, Metropolitan, Triboro, and Van Etten Hospitals. These clinics are sponsored jointly by the department of health and the health and hospitals corporation thus "combined" and their primary focus is upon providing comprehensive medical care to the active or recently active tuberculosis patient.

Serving as both initial and backup care units, the combined chest clinics have at their disposal the sum of medical services available in municipal hospitals. In addition to tuberculosis care, the patient can receive treatment for most other medical problems which can be cared for on an outpatient basis. Methadone treatment for tuberculosis drug addicts is also incorporated into the Harlem and Van Etten Combined Chest Clinic structure. As of December 31, 1971, the combined chest clinics were providing care to 6,500 tuberculosis cases. Despite the high incidence of drug abuse and alcoholism among tuberculosis patients, 97 percent of the combined chest clinic patients were receiving current drug therapy. In contrast, when baseline data was first gathered in 1964, only 37 percent of the patients with active tuberculosis were receiving current drug therapy while the remaining 63 percent of patients were unsupervised and in the community spreading tuberculosis infection to others. The national average according to NCDC is 73 percent under current drug therapy.

In addition to the unprecedented level of care which the combined chest clinics provide, these clinics also represent an alternative to the hospitalization, or lengthy hospitalization of a tuberculosis patient. Because the combined chest clinics contain the resources necessary to care for the most complex or difficult tuberculosis patient, it is not uncommon for a patient to receive all of his care on an ambulatory basis or, if hospitalized, not to spend more than a few weeks as an inpatient. As the direct result of the combined chest clinics, 600 municipal tuberculosis hospital beds have been eliminated over the past 3 to 4 years which by conservative estimate represents a program saving of $45 million.

The project also provides support to New York City's hospital admission X-ray program which since 1968 has discovered approximately 24 percent of all new active tuberculosis cases reported anually in New York City.

Federal grant funds have been directly responsible for development of our most exciting and innovative concept, health aide followup. In this program community members, often former tuberculosis patients themselves, bring or return tuberculosis cases, contacts, suspects and associates to clinic supervision.

Some of our health aides are rehabilitated former addicts now on methadone maintenance who can relate as no professional has been able to, to the average tuberculosis patient whose disease is compounded by the oppressive problems of alcoholism and drug addiction.

As a result of our health aide activities, the number of patients lost to supervision has been markedly reduced. More than 20,000 patient visits each year are conducted by them. Career ladder mobility is provided by promotions to supervising health aide and clinic manager. Three of our clinic managers got their start as health aides.

In this brief program review I have endeavored to show how the tuberculosis program in New York has been vitalized and upgraded by the Federal project. The authorization, however, expires June 30, 1972, and we have already been notified no project funds will be available thereafter, even from previous authorizations.

As I pointed out, tuberculosis is almost wholly an urban problem of disadvantaged minority group persons. Through the treatment of tuberculosis we have gained access to, and kept these patients in the medical care system providing comprehensive care to them. Federal funds have been largely responsible for bringing the new case rate from 62.9 in 1963 to 32.8 in 1970. Hospital beds have been decreased by 600 in the last 3 years.

The level of care of our tuberculosis patients in unparalleled anywhere in the world, but all this is in danger as of June 30, 1972, when due to withdrawal of Federal funds we will be forced to close our eight hospital based combined clinics and transfer 6,500 tuberculosis patients to other, inadequate facilities. The result clearly will be a decrease in tuberculosis surveillance, longer hospital stay, and ultimately, a reversal of the downward trends in this disease that we all have been so proud of. This will be a health crisis in New York and in the 18 other cities in which Federal grant funds will be discontinued June 30.

Public health experts universally agree that good public health practice, as well as commonsense, dictate that constant pressure and support are required to eradicate those diseases in which progress has been made, but continue to exact their toll of morbidity and mortality. Tuberculosis which exists as a prism through which one can view deficiencies in health care delivery, is clearly one of these.

The example of venereal disease should not be forgotten by this subcommittee. One of the major determinants of the shocking rise of venereal disease cases, which this subcommittee is addressing itself to, in consideration of S. 3187 introduced by Senator Javits, and others, was the severe diminution of Federal support in the mid-1960's largely because of complacency brought on by an earlier rapid falloff in rates, which in turn was brought about by input of Federal funds and personnel. We cannot afford to let history repeat itself.

I have two more brief observations which I would like to express at this time out of my concern for the legislation at hand.

In fiscal 1972, no funds were appropriated for tuberculosis control. The reason given to us by the regional health director was 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. With this in mind the State health commissioner was approached to see if such supplemental support could be arranged. He was extremely supportive and cooperative, but explained that these 314(d) funds support a considerable number of essential State health services ranging from muscle retardation to district health installations. The 314(d) funds channeled to the city

of New York for tuberculosis could not be increased without detriment to these other vital programs.

The lesson to be learned from this I feel is that until we have a categorical tuberculosis support authorization, funding for the innovative and successful projects described earlier will be dependent on many other factors, health, as well as short-term political priorities. This will be to the detriment of good public health practice and planning, and, unfortunately to the progress which has been made.

The second additional point I would like to address myself to is the concept of categorical care versus comprehensive care. Speaking for myself I must applaud any effort 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. Deiter Koch-Weser of the Harvard School of Public Health, has found marked deficiencies in medical education pertaining to tuberculosis throughout the country.

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 that 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 feeling and those of the Health Department, Health Services Administration of New York City.

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

Could you give us your estimate of the cost to control the tuberculosis problem in New York?

Dr. REICHMAN. I think that the job that we are doing now in New Nork City is a cost-effective job. We now spend a total of $40 million a year in New York City, although $35 million of this is for hospitalization.

As we cut the number of beds in hospitals in combined chest clinics and the like, these funds are put into other use.

Of course, as is the rule in public health everywhere, there is no incentive to change, and these funds are not put into the ambulatory care treatment, which makes the cuts in beds possible; they are put into other general programs.

Of the $40 million, $5 million is for outpatient care. Our Federal grant moneys come to $764,000, and that is the money that runs these eight combined clinics I talked about.

That is the most significant part of tuberculosis control in New York City, so in direct answer to your question, I would say we need to have the $764,000 restored.

We have a cost-effective program, one which has proven to do its job, and we do not want any more money than we need to do the job.

Senator Hughes. Then apparently your feeling is that the formula-grant programs to States for TB just are not going to reach your objectives at all.

Dr. Reichman. We do get some money, Mr. Chairman, from the formula-grant program. In New York State that program puts in 25 percent for TB control, and it goes to various upstate areas.

In New York City the figure is about $600,000. However, the breakout for the over $6 million of formula-grant funds shows that this would not be able to be increased.

When we heard our money was going to be cut, we checked it as I said in the prepared testimony, and we found this would not be increased because of the other vital services upstate.

Senator Hughes. Could you list for us the other 18 cities that would also have cuts in grants?

Dr. Reichman. Yes, sir.

Senator Hughes. If you have them there, you may read them into the record; if not, you may furnish them later.

Dr. Reichman. As you wish.

Senator Hughes. Go ahead and read them in the record.

Dr. Reichman. Following is a list of Federal funds designated for tuberculosis control in fiscal year 1971 under 314(e) and 317, which will cease after June 30 unless new appropriations are made.

Region 2: Newark, $50,976; Erie County, N.Y.: $33,422. New York City, $613,072. Puerto Rico, $108,170.

Region 3: Washington, D.C., $298.769; Baltimore, $70,331. Pittsburgh, $34,000. Alabama, $204,510. Dade County, which is Miami, $53,240, rest of Florida, $10,000, Fulton County, which is Atlanta, $39,950.

Region 5: Detroit, $112,200.

Region 6: El Paso, Tex., $28,560. Houston, $83,810. San Antonio, $45,560.

Region 7: St. Louis, $39,950.

Region 9: San Francisco, $58,140. Hawaii, $51,340.

Region 10: Alaska, $64,000.

The total, as I have it here, is $2,000,000.

Senator Hughes. Thank you very much, Dr. Reichman.

Senator Dominick.

Senator Dominick. Dr. Reichman, if I read your testimony correctly, on page 5 you say: "Project funds and personnel are not used to offset city tuberculosis expenditures, nor is the project scheduled within the city budget." This enables you to do a better job with increased flexibility; is that correct sir?

Dr. Reichman. Yes, sir.

Senator Dominick. I think if that is true why would the same thing be true of HEW?

Dr. REICHMAN. Excuse me?

Senator DOMINICK. Why would it not be true also under the Federal funding if you put it under 314(b) or 317, rather than having a specific program.

Dr. REICHMAN. I think this may be true as far as Federal funding is concerned, but at this time I am looking at it from the grave TB problem we have in New York and other parts of the country, and I am worried that funds will not get down to the big city areas where we have the severe TB problems.

Senator DOMINICK. The point is you say you are able to do a better job because you are not within the program activity within the city budget.

Dr. REICHMAN. Right.

Senator DOMINICK. Why would not the same thing be true insofar as trying to do something here in communicable diseases, which would give them a flexibility also to move in the areas which need it most?

Dr. REICHMAN. I think it probably comes down to the fact that you know where you need to have flexibility. I am addressing myself to a categorical disease entity which needs to be controlled and which should have been controlled a long while ago.

The project has given us this flexibility. I am afraid if we put this flexibility at a higher level of dispersal, we would not be able to get this down to the cities where we need this flexibility.

Senator DOMINICK. It is my understanding from listening to Dr. DuVal earlier this morning that they have not been really using this communicable disease specific programing but they have been doing most of it under 314(e); is that correct?

Dr. REICHMAN. Up until a few years ago that is correct, and then under the 317 money was put in to assist in the phase out of TB programs by the Federal Government. I believe that was the way it was stated.

Unfortunately these programs have been developed to such a high level of excellence, I think that you just cannot phase them out.

The problems involved in, for instance, the city of New York—you are probably aware that it has a monumental budget deficit of its own; the State has one. To have them increase their funds to take over this program would mean they would have to take it from some other high priority.

So what we are left with is that we have been helped to develop a fantastic program. We have been helped to develop this program by the Federal Government through this legislation, and now it is to be withdrawn from us.

Senator DOMINICK. For the record I should point out there is a terrible deficit in the Federal budget as well, so we have the same problem, regardless of at which governmental level you are.

I think that is all I have, Mr. Chairman.

Senator HUGHES. Thank you very much, Senator Dominick.

Dr. Reichman, we will send you some more questions in writing, and we will be pleased if you will respond to them for the record.

Dr. REICHMAN. Thank you.

(Further information received from Dr. Reichman follows:)

DEPARTMENT OF HEALTH
125 WORTH ST., NEW YORK, N. Y. 10013
Telephone: 566—

April 19, 1972

Hon. Edward M. Kennedy
Chairman
Subcommittee on Health
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

Thank you very much for your letter and kind words on my testimony before your Subcommittee on Health on April 10th. Enclosed please find my answers to the questions you proposed. Please note that I have appended to the answer to Question 4 our new active case distribution and rates for 1971 which became available this week.

Underlying these answers is the constant fear that no matter what the authorization is pertaining to tuberculosis we will again face the difficulty that we are currently experiencing due to the fact that no appropriation has been forthcoming for tuberculosis control for FY-1972.

I would like to take this opportunity to respectfully invite you and the other members of your committee, as your schedules permit, to visit one of the combined chest clinics referred to in my testimony. These are, I proudly feel, a glowing example of what has been done with limited federal resources. These are the clinics which are in direct danger if an appropriation is not forthcoming.

Many thanks for your kind consideration and cooperation.

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH
Lee B. Reichman, M.D., M.P.H.
Director
Bureau of Tuberculosis
Room 1000
93 Worth Street
New York, N.Y. 10013

Sincerely yours,

Lee B Reichman

Lee B. Reichman, MD, MPH
Director
Bureau of Tuberculosis

Consultant for TB Activities
NYC Health and Hospitals Corporation

LBR:hk

ANSWERS TO QUESTIONS

FOR HEARING ON S. 3442

Lee B. Reichman, MD, MPH

Director

Bureau of Tuberculosis

New York City Health Department

Consultant for TB Activities

New York City Health and Hospital Corporation

ANSWERS TO QUESTIONS FOR HEARINGS ON S. 3442

1. Q. What value and need do you place on the Communicable Disease Control Amendments of 1970 in view of the Administration's specific and repeated request that this legislation need not be extended? Do you believe that funding for communicable disease programs can be accomplished under other existing legislative authority?

A. The Communicable Disease Control Amendments of 1970 to my mind represent the closest thing to a commitment by the federal government to do something about these 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 enable us to reach that goal. In the communicable diseases the research has been done. All that is necessary now is the delivery of the fruits of such research to those citizens, usually the poor and disadvantaged, who most deserve to be the beneficiaries of this research.

The Administration's specific and repeated request that this legislation need not be extended is, I imagine, because of their desire for flexibility and their priorities for new methods of health care delivery. I submit, however, that their flexibility has not addressed itself sufficiently to these curable and eradicable problems. As I said in my prepared testimony, health maintenance organizations cannot at present deal with the categorical problems such as tuberculosis, which cannot be looked at comprehensively without considerable planning and reorganization.

I have no question that funding for a communicable disease program cannot be accomplished under any other existing legislative authority. This has been amply shown in New York State where 314 (d) appropriations are used to cover other essential Upstate health needs. With the turning off of direct project grants under Section 317 because of the fact that no money was appropriated for tuberculosis control, even though the authorization was ample, 314 (d) funds could not be increased to avoid a funding gap that would necessitate the closing of our 8 combined chest clinics. The fact that the clinics that have done the most for tuberculosis control in New York City, as outlined in the prepared testimony, will have to close, is proof that other legislative authority is inadequate to deal with the problem.

2. Q. Are the present DHEW communicable disease programs achieving the impact Congress intended? If not, what do you recommend for an effective program?

A. In general, yes. This, of course, depends to a great extent on the use to which federal funds are put. Change is often very difficult to foment. Medical thinking about a disease such as tuberculosis has turned us around 100%. Strictly categorical health workers who have devoted their lives to the problems of tuberculosis are nowto a great extent doing things "the new and right way". This is mostly due to the efforts of the Tuberculosis Branch, State and Community Services Division, National Center for Disease Control, Health Services and Mental Health Administration, Department of Health, Education and Welfare. There is still much to be done. An effective program must not be stopped for whatever reason just when it is beginning to show its effect.

3. Q. Could you comment on the ending of federal support for tuberculosis programs in the nation? Do you believe that tuberculosis will continue to wane without federal support?

A. The ending of federal support for tuberculosis programs will have a detrimental effect on these programs. Using federal funds, most cities that I know have set up a cadre of experienced, dedicated workers who have, I believe, made a great difference. This is reflected not only in declining case rates, but in savings in closing of hospital beds. Tuberculosis will probably continue to wane without federal support in some areas, namely, in the rural areas and in the white and middle upper classes where the rates are lowest to begin with. We have shown that tuberculosis is a disease of disadvantaged minority groups, groups which do not get their share of health services delivered to them. Special tuberculosis control efforts are needed in these groups and have been provided successfully to them in New York City. Without federal support the programs will die and the morbidity of tuberculosis will probably cease to wane. The 1968 Mayor's Task Force on Tuberculosis in New York City concluded that tuberculosis is a disease that exemplifies the great social problems of our time but it was felt that much could be done to eradicate the disease now even while the social problems are still being considered. Without comprehensive effort to eradicate the disease I sincerely would expect a rise in morbidity among these disadvantaged groups.

4. Q. In your testimony, you noted that federal funding of your tuberculosis program will be terminated. Could you describe what this means in terms of tuberculosis control in New York City?

A. Unless new sources of funding are found the City of New York will have to close its 8 combined chest clinics. These clinics give comprehensive care to 6,500 tuberculosis patients. These are more complicated patients that exist in our other clinics. Without federal support of the combined clinics

the level of care will probably fall back to what occurred in 1963 when preliminary data was gathered prior to their inception. At that time 37% of the patients were under current medical supervision. In tuberculosis, if a patient is not under supervision he is by definition out in the community spreading the disease. Therefore, 63% of patients were not being controlled and were spreading the disease. In 1971 the study was repeated. At that time 98% of patients were under current supervision. The national average for 1970, patients under current supervision, is 73%. With the closing of the combined clinics the 6,500 complicated patients would necessarily be referred to other inadequate facilities or would have to be cared for as inpatients at a cost of $127 each per day. I must repeat myself in that most of the progress we have made in tuberculosis control in New York City is due entirely to the concept of providing comprehensive care to the tuberculosis patient in the context of his tuberculosis, which makes him a captive of the medical care system for the duration of his treatment. This is the charge given to the combined chest clinics and this is what would be lost if these clinics were closed. Briefly, other difficulties that we would have to encounter would be the inability to train young community oriented physicians, nurses and community people in considering tuberculosis in the mainstream of medicine. 109 project paid employees would have to be terminated of which 71 represent minority groups, many of whom are former tuberculosis patients themselves. We have found that individuals from the community can relate as no professional can to the patient concerning his problem, and our extremely low lapse rate reflects this clearly.

Appended to the report is the new case data with rates for 1969, 1970 and 1971. As can be seen the case decrease for 1969-70 does not occur in 1971. Brooklyn and Queens show a marked rise in new active cases. Clearly this is not the time to decrease support.

5. Q. What will be the priority given for tuberculosis programs in New York State when federal funding is stopped?

A. The State of New York has indicated to us that they are very concerned about the tuberculosis control program. They have recently assured us that the 314 (d) formula money earmarked by them for tuberculosis control in New York City will not be decreased in fiscal year 1972. However, they too are in a bind when it comes to other programs and as in my answer to question (1) above, and in my prepared testimony, it has been shown that the state cannot support additional outlays for tuberculosis control in New York City because of their own other priorities on the use of this money, much as they would like to. Authorizing specific earmarked

tuberculosis project funds obviate the use of such money for other priorities many of which are likely to be short term and political as opposed to good public health practice.

6. Q. For fiscal year 1973, the Department of Health, Education and Welfare has requested $\$14\frac{1}{2}$ million for vaccination assistance, \$10 million of which is for rubella, and $\$4\frac{1}{2}$ million for all other immunizations. Could you comment on this appropriation request? Will it meet the need for the coming year in the prevention and control of communicable diseases?

A. $14\frac{1}{2}$ million dollars for vaccination assistance will certainly be a welcome boost to the efforts of the immunization program. Immunizable disease is clearly one category of disease that fits into the description of entities that the Communicable Disease Amendments seek to eradicate. From a public health standpoint, however, immunizable disease eradication is entirely different than eradication of tuberculosis and venereal disease. With immunizable disease one contact between the health worker and the exposed individual is all that is required.

In venereal disease, highly specialized conferencing of the patient with contact follow-up is necessary. With tuberculosis, contact follow-up is also necessary, but 2 years of treatment of an asymptomatic individual which is required to take the patient out of the pool of those who remain a public health danger is an entirely different problem.

When a new active case of tuberculosis is found, the patient must be interviewed, and his contacts and associates brought in for surveillance. After undergoing diagnostic tests the patient is placed on chemotherapy, usually as an outpatient. The only indication for hospitalization in New York City's program is illness of the patient and since patients become symptom free in a short term those that are hospitalized are then discharged to outpatient follow-up. What sets tuberculosis apart from the other diseases mentioned in S. 3442 is that tuberculosis requires an asymptomatic patient to take medication and be followed at monthly intervals for 2 years in order to render him cured. If this doesn't occur he is a danger to his community as well as himself.

It is for this reason that I feel very strongly that tuberculosis cannot be considered just another communicable disease, but a unique communicable disease that must be mentioned by name in legislation and that everything that can be done must be done to assure that there are appropriations

provided to go along with authorizations to be passed.

I cannot understand why the Department of HEW can request a clearly categorical sum for vaccination assistance while callously ignoring other categories of communicable disease that will not be affected by vaccination assistance and that clearly remain major public health problems.

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NEW ACTIVE TUBERCULOSIS CASES REPORTED
BY BOROUGH AND HEALTH DISTRICT OF RESIDENCE
NUMBERS AND RATES
New York City, 1969, 1970, and 1971

Health District	Number			Rate per 100,000 Pop.****		
	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	232*	225**	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.[illegible]
Jamaica East	99	82	97	28.8	23.8	28.[illegible]
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

* 1969 includes 98 homeless men.
** 1970 includes 102 homeless men.
*** 1971 includes 89 homeless men.
**** 1969, 1970 and 1971 rates are based on 1970 Census of Population.

Bureau of Tuberculosis Control
Bureau of Health Statistics and Analysis
JK/ls 4/13/72

Department of Health
Health Services Administration
The City of New York

Senator HUGHES. The Chair now calls Dr. William Schaffner of the Department of Medicine of Vanderbilt University School of Medicine, who is representing the Action Committee for Childhood Immunization.

STATEMENT OF WILLIAM SCHAFFNER, M.D., DEPARTMENT OF MEDICINE, VANDERBILT UNIVERSITY SCHOOL OF MEDICINE, AND ACTION COMMITTEE FOR CHILDHOOD IMMUNIZATIONS

Dr. SCHAFFNER. Mr. Chairman, I apologize for not having a manuscript of my prepared testimony. It is brief.

I represent the Action Committee for Childhood Immunizations. It is a newly formed nonprofit group of physicians around the country who are sufficiently concerned with the immunization problem that we have gathered together with almost no funds to try to do something about it.

Let me point out that vaccines are available that can protect every child in this country against well-known crippling and killing diseases such as measles, polio, diphtheria, and tetanus; and that cost-benefit studies demonstrate that the gains from immunization procedures are among the greatest to be achieved from any existing public health practice.

If you eliminate the disease, you completely eliminate the need for the diagnostic, therapeutic and rehabilitative structures attendant on that disease.

I would submit that we are not now effectively or comprehensively protecting American children with available vaccines. What we think is needed is national recognition of the situation in a long term Federal commitment to a coordinated plan for the control of these diseases.

You ought to know, lastly, that research is underway which will result in the availability of several new vaccines within the next decade. But we have been unable to effectively use the vaccines we now have. We need to quickly set up a more effective vaccine distribution system, or the failure of the new vaccines is preordained.

Immunization activities have in the past decade been subject to eratic funding, and fads in funding. It has almost been the "disease of the year" approach. In the middle 1950's we were interested in polio. In the middle 1960's when I was in the Public Health Service we were terribly interested in measles. With the advent of rubella vaccine, measles funding diminished, and attention was directed to the administration of the rubella vaccine.

Local and State health departments responded with a distribution of effort dependent upon how these vaccine funds were distributed. I think what we need is a stable, long term commitment to the entire package of immunization of children. Let me give you some quick examples, and then I will stop for your questions.

Measles is our most recent and most dramatic example of immunization failure. This is a disease that we ought to protect children against. One out of every thousand gets encephalitis, and one out of every 10,000 dies. It disrupts schools, and is costly in terms of physicians and other health personnel manpower.

Measles is resurgent today, despite the fact that in the mid 1960's we were talking about the eradication of this disease. Last year there were some 75,000 cases in all economic groups all over this country.

This is a clear result of the dimunition in Federal measles money attendant on the advent of the rubella vaccine, and the shift of activity to immunizing children against rubella. When the money went into the rubella program, measles immunization activity diminished.

I think the disease that has most of us uneasy is polio. As Dr. Sencer said this morning, the incidence of this disease has dropped dramatically. Last year I believe he said there were only 12 cases in this country. There used to be over 5,000 reported annually. This is a fantastic achievement.

Nevertheless, what makes us uneasy are the results of the 1971 immunization survey, which was performed by the Bureau of the Census in association with the CDC. Only two-thirds of our children in the age group 1 to 5—only two-thirds—are adequately immunized against polio. This has been a steadily increasing problem that just plateaued last year.

While this immunization gap is most apparent in the poverty areas of our central cities and in remote rural areas—that is where it is most apparent—what is making me even more uneasy is that white suburban children are also not adequately immunized, about a third of them. These are children who presumably have access to good pediatric services.

So we believe very strongly that Federal funding ought to continue in a categorical fashion. The priorities established by States and local health departments just do not, for reasons that I am not quite clear on, include vigorous, and aggressive immunization programs.

I think that the public education aspects of the bill are terribly important. Innovative educational efforts are necessary to overcome the complacency that apparently has developed regarding immunizing our children against immunizable diseases such as polio.

I would commend the provisions of this bill to your attention, and would reenforce the idea that we need a long term commitment to these immunization programs.

I will answer your questions.

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

Does the committee agree with the administration that existing legislation is sufficient to deal with these diseases?

Dr. SCHAFFNER. No; I think that the immunization activities of the past several years suggest that noncategoric funding is not sufficient.

Recently some money has been released for polio and measles vaccines. These moneys were dependent on a price drop in rubella vaccine in the open market.

I do not believe that intelligent long-term planning can take place depending upon these vagaries of the marketplace. I do not believe we ought to decide whether to protect children against polio on the basis of how much rubella vaccine costs. That does not make any sense to me.

Senator HUGHES You mentioned the fact that even in white suburbia approximately one-third of the children in this age category of 1 to 5 are not being adequately immunized against polio; that they may be partially immunized.

Dr. SCHAFFNER. Certainly these are the kids who are in contact with physicians constantly. This has troubled a lot of us. We do not really know why this happens, but let me suggest a reason.

In fact, it is the reason you suggest. A lot of pediatric practice is crisis-oriented, that is, the child visits the pediatrician at a moment when he is sick with an illness. For a variety of medical reasons this is not the time to immunize him.

It may be in that setting the mother is told, "You must bring Johnny back for his polio vaccine, or his other vaccine, at some subsequent time." It is that admonition which goes unheeded. At least, this is my current theory, and I believe this is why children are not adequately immunized.

Senator HUGHES. Do you think it would be good to put the two bills, S. 3442 and S. 3187, together; combine these two?

Dr. SCHAFFNER. Is that a strategic question? I do not know. I think that is outside my ken.

Senator HUGHES. You will leave that up to the committee; is that right?

Dr. SCHAFFNER. Yes.

Senator HUGHES. S. 3442 has eight or nine special programs for public education to deal with.

Dr. SCHAFFNER. It does.

Senator HUGHES. Do you think this is going to reach everyone?

Dr SCHAFFNER. I think it is a good start, and I think you can monitor very carefully what happens. I think it clearly ought to be encouraged.

It is, after all, the reason that we nine doctors have gotten together in an attempt to do this. That is one of our distinct goals, to educate not only physicians but, even more important, to educate the consumer who is probably the mother in this case.

Senator HUGHES. Concededly there is not as much danger from polio for people my age because of our exposure over the years and the probablility that many of us have had mild cases, particularly during the epidemic times.

But, as I sit here, I am not sure that I am properly immunized myself. I really do not know whether I ever completed the immunization program. How well do you think the adult population is protected?

Dr. SCHAFFNER. I think at the present time the CDC's excellent figures would indicate that the adult population is reasonably well protected. Certainly those cases that continue to occur are occurring in the preschool and schoolage children. The immunization survey would indicate that those over 20 are reasonably well immunized against polio.

Senator HUGHES. I think in the interest of the time remaining, Dr. Schaffner, we would like to submit some additional questions to you in writing.

Dr. SCHAFFNER. Thank you.

Senator HUGHES. Thank you again for being here.

Our next witness is Dr. Robert J. Anderson of the National Tuberculosis and Respiratory Disease Association. Dr. Anderson, welcome to the subcommittee. You may proceed with your testimony.

STATEMENT OF ROBERT J. ANDERSON, M.D., MANAGING DIRECTOR, NATIONAL TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION

Dr. ANDERSON. Mr. Chairman and members of the committee, the National Tuberculosis and Respiratory Disease Association strongly 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 2 years ago.

I should add that we supported the legislation when it was before this committee 2 years ago.

TB FUNDING UNDER THE ACT

We would like to speak first about the grave situation which has arisen in relation to support of tuberculosis control under Public Law 91–464. Because the act does not authorize amounts for specific disease entities, use of appropriated funds is dependent on the interests of the administration and the appropriations committees.

It was that lack of categorization in the comprehensive health program which enabled the administration to delete tuberculosis first as an eligible project for funding under section 314, and caused us to come in to support Public Law 91–464.

In fiscal 1972, no funds were specified by the appropriations committees for tuberculosis control. None of the $4 million whose use was left unspecified by the committees was allocated by the Department of Health, Education, and Welfare to tuberculosis control. For the first time in decades there are no funds designated at the Federal level solely for support of tuberculosis programs.

What does this mean? The city of New York is having to discontinue eight chest clinics caring for 6,500 patients. No additional 314(d) funds can be anticipated although State health officials are sympathetic to the plight in which the city finds itself.

Newark health officials believe that the loss of Federal project grants for their tuberculosis program will have catestrophic results. The city of Philadelphia can expect no more State or local funds to make up for the loss of project grant support. The tuberculosis program of the District of Columbia has succeeded in corralling funds from numerous sources to help meet the emergency but even so, the tuberculosis program staff has been reduced 115 to 65; the weakening of the official agency's control over tuberculosis is already apparent.

City officials know these facts but it is understandable that many will not find the necessary funds to maintain tuberculosis control programs. All are in financial straits and face everproliferating demands on their limited resources.

Our organization sees no solution to this situation unless there is included in the act, for as long as is necessary, separate authorizations for (1) tuberculosis control, (2) venereal disease control and (3) immunization programs.

S. 3187 recognizes that the problem of venereal disease control needs special legislative attention. The potential for prolonged and complicated illness from these infections is similar to the consequences of tuberculosis infection, if allowed to go untreated. Control programs for tuberculosis and venereal disease are continuous operations and as such need sustained support. They use similar management techniques. The techniques of controlling these diseases are very different from the methods used for controlling other communicable diseases in which vaccinations of large groups of children or adults is all that is essential.

In both diseases, control is a time-consuming operation. The tracing of contacts of known 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 in large cities, but they must be convinced to come in for examination. Those infected with tuberculosis 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 operation means not only a halting of progress, it can portend an upsurge in cases. Tuberculosis and venereal disease control need as much assurance of support of their ongoing operations as it is possible for this act to provide.

We would also like to point out that section 317(f) of the existing law requires that the Secretary of Health, Education, and Welfare describe effectiveness of the activities of the Department in preventing and controlling communicable diseases. Such a report can ignore a disease for which the Department is providing no control activities. For example, the critical situation in which tuberculosis control finds itself may well not be reflected in the Secretary's report. What we believe would be more revealing would be a report on the status of each of the various communicable diseases and changes over the previous year. In this way, Congress could evaluate the specific disease situation in relation to Federal support and activity.

We believe the addition of contract funds for public education in new sectoin 317(h) of S. 3442 is very worthwhile. It would be especially valuable in times of large immunization campaigns. Incidentally, on these funds for education I think this would enable an effective partnership to develop between many kinds of public and nonprofit organizations, including the voluntary health agencies, in active educational programs during immunization campaigns.

PROGRAMS FOR FEDERAL SUPPORT OF TUBERCULOSIS CONTROL

After the Comprehensive Health program was initiated in fiscal 1967, communicable disease programs became dependent on that program for support. In the case of tuberculosis control, support under CHP 314(e) project grants lasted until 1970 when the Department stated that such programs would henceforth be funded from 319(d) formula funds.

That assumption was ill-founded for two reasons. One is that States receiving the most money under the formula grant program are not necessarily the ones with the greatest tuberculosis problems. More important, however, the increase in 314(d) formula funds has been minimal. From the beginning, inflation and increasing demands for these funds made the prospect of tuberculosis programs obtaining adequate support under the 314(d) program unrealistic.

The Communicable Disease Act can assure the kind of continuity of support which is not possible under the Comprehensive Health program. Under that program, project grant support for any communicable disease can be withdrawn at any time, as the health priorities of the administration change.

THE TUBERCULOSIS PROBLEM

In 1970 there were 37,137 new active cases of tuberculosis reported in the United States. This does not represent a vanishing deases. Today tuberculosis is a disease which lingers on mainly in the congested areas of our cities where people are poor. Poor people are the ones least apt to have private medical attention and hence to discover that they have the disease. Case rates among nonwhites are five times higher than among whites and for the first time in recent years the decline in nonwhite cases appears to have come to a halt.

As a matter of fact, Mr. Chairman, 1970 was the first time the number of deaths from tuberculosis went upward since 1952 when antituberculosis drugs were discovered.

Examination of case rates by geographic area illustrates the concentration of tuberculosis in enclaves of our population. New York City, which had a rate approximately twice the national average in 1970, includes areas where the rate is six times that high. Compared with a case rate for the country as a whole of 18 per 100,000 population in 1970, El Paso had a rate of 64, Baltimore a rate of 54, Birmingham a rate of 53, and Newark a rate of 52. Persons living in high prevalence areas often work in other areas of the city. Our mobility is a national characteristic; none of us is safe from exposure to communicable disease.

Another significant factor which cannot be ignored in assessing the needs in tuberculosis 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 tubercle bacillus.

These persons are examined on entry for presence of active tuberculosis. However, examinations cannot foresee the rate at which they may break down with tuberculosis. About three-fourths of the near-active tuberculosis cases in Hawaii in recent years are among immigrants, many of them from the Philippines. The city of Honolulu, which has an excellent tuberculosis program, has the third highest rate among cities of 250,000 population and over. A quarter of the new active cases found in immigrants to Hawaii develop at least 5 years after the immigrant arrives.

DISEASE PREVENTION

Placing States and communities in the position of having to cut back or abandon an effective communicable disease program because of inadequate support is truly a tragedy. There is much rhetoric in public health circles today about the need to promote preventive health services in order to reduce the spiralling costs of medical care. Obviously, this is 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 the etiology of these diseases and we know how to prevent them and treat them successfully.

For many years it has been known that tuberculosis is caused by a bacillus, and that isolation of the patient with active disease protects the healthy population from contracting the infection. The long hos-

pitalization formerly necessary to achieve this objective was expensive, and a grave hardship on the patient who was required to spend months away from his family and friends.

With the discovery of antituberculosis drugs 2 decades ago, the future treatment of this disease was due to become revolutionized. Today it is rare for a patient to have more than a short hospital stay. Patients become noninfectious in a short period of time. Most are able to arrest their disease solely by the conscientious taking of medication over a period of 18 to 24 months, under the supervision of clinic personnel or private physicians. Obviously the more outpatient care, the less cost of tuberculosis control, particularly 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. The fact that more than a third of all new active cases are found in a far advanced stage shows that much remains to be done in tuberculosis control.

If allowed to go untreated, tuberculosis patients have as much risk of dying as did those of previous generations; the infant who becomes infected with the tubercle bacillus has the same astronomical risk of succumbing to death from meningitis or disseminated tuberculosis. Thus the availability of effective drug therapy makes it even more of a tragedy when tuberculosis control programs are cut back.

IN CONCLUSION

The Communicable Disease Act must be extended if we are to continue to make progress against diseases which are transmissable from man to man. Without it, we cannot take advantage of opportunities for eradication of these conditions.

Our organization considers that S. 3442 is essential to a responsible national public health policy. We thank the committee for the chance to present our reasons for supporting this important bill.

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

Do you have any idea what you think the reasons might be for the administration to oppose the extension of this legislation, if the need is as great as you say?

Dr. ANDERSON. I heard their stated reasons, that they believe it was unnecessary. I personally feel that it is very necessary.

This matter of communicable disease control is the mainstay of governmental interest in public health. It is the thing that was recognized in the States, in the Federal Government, at the very outset. To make communicable disease control subject to the whims or desires of individuals who for one reason or another are interested in something else, to enable them to chuck communicable disease control is bad public policy.

I believe the Congress in the legislation and in the appropriations process should examine what our posture is with regard to the dangers from communicable diseases, and the measures that are necessary to control them.

Senator HUGHES. Doctor, I want to thank you and compliment you for your fine testimony, and specifically for your recommendation. The committee will consider carefully your testimony. I would simply

like to express our appreciation to you for being with us and giving us the benefit of your testimony.

Dr. ANDERSON. Thank you, Senator.

Senator HUGHES. The Chair calls Dr. Mack I. Shanholtz, the commissioner of health from the Virginia Department of Health. Welcome to the subcommittee.

Dr. Shanholtz, we may have a problem. There is a vote, we are getting near the end of the alphabet, and we are still short of 12 people. I hope you can be as brief as possible, as I may have to leave.

STATEMENT OF MACK I. SHANHOLTZ, M.D., COMMISSIONER OF HEALTH, STATE OF VIRGINIA

Dr. SHANHOLTZ. It is my intention to be brief. I would like to have the entire statement appear in the record, but I would be glad to highlight it.

Senator HUGHES. If you would, we will include your statement as though given in its entirety, and you may highlight it.

I apologize that I have to leave. I am going to let Senator Eagleton take over the chair while I go to the floor. Thank you, Dr. Shanholtz.

Senator EAGLETON. You may proceed, Dr. Shanholtz.

Dr. SHANHOLTZ. In addition to serving as the State health commissioner of Virginia, I am also a member and past president 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 our association for the leadership of the Senators who are sponsors of S. 3442 and S. 3187. We regret that the Department of Health, Education, and Welfare recommended against enactment of the Communicable Disease Control Amendments in 1970. Subsequently, the Department failed to request funds for implementation of the legislation. Since that act, Public Law 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 section 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.

Section 314(d) has been mentioned several times in this morning's discussions. The State department of health in Virginia is a recipient of this 314(d) formula grant, so I can speak with some authority as to what it is being used for.

First of all, it represents a very small commitment, a very small financial commitment on the part of the Federal Government, to our overall budget in terms of dollars. We receive about $1.5 million from 314(d). Our total operating budget for the fiscal year, for the present year we are in, is about $150 million, so you can see this represents a little less than 1 percent of our overall operating budget.

When Senator Hill introduced this legislation back in the middle 1960's, he visualized a gradual increase of 314(d) funds to the States after 5 years, reaching a level of about $300 million, where it could

more rightly be called partnership. It has hardly gotten beyond the initial appropriation.

A good many of the points that I have in this brief presentation have already been covered by other speakers, but it was brought out that communicable diseases are on the increase, and for the first 12 weeks of this year we note that there have been 9,100 cases of rubeola (red measles) reported; 7,785 cases of rubella (German measles); 5,615 cases of tuberculosis; 152,511 cases of gonorrhea; and 5,165 cases of syphilis—just to give you a few statistics.

We are also concerned with the immunization levels. You cannot control diseases with crash programs. We are becoming alarmed by the fact that among children under 5 years of age the national average of protected children is 69 percent in the case of polio, 47 percent in the case of rubella, and 67 percent in the case of measles.

As to venereal disease, I have here a very recent clipping from the Richmond, Va., local paper. It states that venereal disease is the most common disease except for the common cold. For Virginia—I quote:

> There were 17,311 identifiable cases of VD in fiscal year 1971, a 15-percent increase over the previous year. The sorry VD rate in Virginia is consistent with that of the Nation as a whole.

That was an article appearing April 6.

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

Tuberculosis, the No. 1 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.

Our association strongly urges a national commitment to combating diseases that can be controlled or prevented. Such a commitment could be achieved if S. 3442 and S. 3187 were enacted and adequately funded.

We believe, however, that there might be advantages to a consolidation of the provisions of S. 3442 and S. 3187 under a single measure.

First returns from the uniform national health program reporting system being developed by our 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. The new reporting system also showed that State and local funds constituted one-third of the rubella immunization costs. In the case of venereal disease control, the Federal share of 1971 expenditures amounted to only one-third of the total costs. Only 2 percent of the VD control costs were allocated to educational programs.

Consequently, this association strongly supports the provisions of S. 3187 and S. 3442 that relate to health education programs. We endorse the formula and project grants of S. 3187 for the control of vene-

real diseases and also the project grants of S. 3442 for the control of tuberculosis and vaccination assistance.

I will be glad to answer any questions.

Senator EAGLETON (presiding pro tempore). Doctor, I take it, as was the case with every other witness not connected with the administration, you think the extension and continuation of this legislation is absolutely necessary.

Dr. SHANHOLTZ. Yes, sir. I would say it is very urgent.

Senator EAGLETON. And necessary even over the objections of the administration?

Dr. SHANHOLTZ. I did not hear all of the objections.

Senator EAGLETON. If they oppose the legislation, you think they are erroneous in such opposition?

Dr. SHANHOLTZ. I mentioned the 1970 enactment.

Senator EAGLETON. But if the current administration is opposed to the extension of this legislation, you would deem that opposition to be nonmeritorious?

Are you for the opposition, or are you against it?

Dr. SHANHOLTZ. I stated previously that we regretted HEW opposition to the enactment of this legislation in 1970 and I repeat I am for this bill, sir.

Senator EAGLETON. On page 4 of your testimony you mention a uniform national health program reporting system being developed by your association. Could you elaborate a little bit further on what this uniform national health program reporting system is?

Dr. SHANHOLTZ. We are developing a methodology for a uniform national health program reporting system, and we have already had a nationwide field trial on it. This type of information has never been collected about all health programs in the States on a uniform basis.

The specialized bits and pieces of many programs collected by Federal agencies pursuing special interests are not necessarily what you and I need to know. Moreover, it is impossible to add up, to compare or to interrelate these bits and pieces.

The Association of State and Territorial Health Officers with support from HEW has undertaken to do something about it, and we are looking forward to the continuing development of the system, and are confident that it will be able to provide Congress with the factual answers to many of its questions about public health which now remain unanswered for lack of information.

Senator EAGLETON. Thank you very much, Dr. Shanholtz.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)

The American Legion

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★

For God and Country

APR 12 1 28 PM '72

April 10, 1972

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health
Senate Committee on Labor and Public Welfare
4230 New Senate Office Building
Washington, D. C.

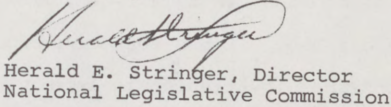
Dear Chairman Kennedy:

In accordance with the suggestion contained in your letter of April 3, 1972, I am submitting herewith a statement prepared by the Director of our Commission on Children and Youth expressing the views of The American Legion on legislation dealing with communicable disease control.

It will be appreciated if you will include this statement in the record of the hearings now being conducted by your Subcommittee on S.3187 and S.3442.

Your continued cooperation with The American Legion is appreciated.

Sincerely yours,



Herald E. Stringer, Director
National Legislative Commission

Statement of Fred T. Kuszmaul, Director
Americanism and Children & Youth Division
The American Legion
on
Communicable Disease Control

Before the
Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate

April 10, 1972

The American Legion appreciates the opportunity to express its views on bills pending before this Subcommittee which would strengthen the federal government's activities and fiscal support to more effectively control communicable diseases.

Through its Children & Youth Division the Legion has been vitally concerned for many years with the control and eradication of communicable diseases which affect children and youth. We have expressed our views to the Congress on numerous occasions supporting measures which would have provided immunization protection of our children against many dreaded childhood diseases and supported measures for increased funding of the federal government's role in the prevention and control of venereal diseases.

Several years ago the United States Surgeon General announced a ten year plan to achieve the eradication of syphilis. It appears almost paradoxical that in recent months we have learned of increases in this disease. It has been common knowledge for several months that gonorrhea is at epidemic levels in many communities throughout the United States and is the most prevalent communicable disease today in America with the exception of the common cold.

Evidence accumulated over the past several years seems to indicate that there is a direct correlation between the incidence

of venereal disease and the level of federal funding for venereal disease control. It appears obvious to us that if the present trend in the incidence of venereal disease is to be reversed, increased federal funding for traditional venereal disease prevention and control programs by the various states and local communities is absolutely essential. Experience has shown that federal assistance for such activities must remain at meaningful levels until such time as medical science is successful in developing effective vaccines for venereal diseases.

Several months ago we were shocked to learn from U.S. Public Health data that the immunization levels for certain serious childhood diseases such as diphtheria and polio dropped dangerously low in some localities in rural areas and particularly for young children in inner city areas; in fact to levels where epidemics of polio might occur.

The American Legion is also concerned that the number of cases of measles has been increasing and is now at the highest level since 1966. This increase has occurred despite the fact that an effective measles vaccine has been available since 1963. Complications from measles can result in serious disorders such as mental retardation, pneumonia, encephalitis and deafness.

Much progress has been made in immunizing children against rubella since an effective vaccine became available in 1969. However, the present level of immunization against this disease, which can cause such horrible damage to the unborn child, is still unsatisfactory. Although national levels of rubella immunization for specified age groups of children continue to improve, there are communities where

many children remain unvaccinated. To the best of our knowledge a cyclical outbreak of this disease is still forecast for the early 1970's.

The American Legion and its Auxiliary have been active in the past year in initiating or participating in neighborhood and community rubella vaccination programs and we have learned of shortages in public funds to provide the necessary amounts of rubella vaccine.

It seems almost inconceivable that many American children are still today suffering the consequences of communicable diseases which are preventable. Achievement of 100 per cent protection of children against such diseases, however, is not entirely related to adequate financing. Continuing education of parents to the importance of immunization of their children is an important factor in achieving this goal. Of uppermost importance in obtaining adequate protection for our children is an adequately financed and aggressive federal program of communicable disease control.

We strongly urge this Subcommittee to take favorable action on the proposals before it which would greatly strengthen venereal disease prevention and control and provide for a meaningful immunization program for our nation's children.

Attached to this statement are Resolutions No. 74 (Immunization of Children) and No. 103 (Venereal Disease Control) adopted at the last National Convention of The American Legion. These resolutions reflect the current policy of our organization with respect to these subjects.

National Convention
Houston, Texas
August 31-September 2, 1971

Resolution No. 74 (North Carolina)

Immunization of Children

WHEREAS, The American Legion has been active in supporting the development of vaccines to prevent many serious childhood ailments including poliomyelitis, diphtheria, measles, whooping cough and rubella; and

WHEREAS, There are available today vaccines which afford children protection against these dreaded diseases; and

WHEREAS, Recent statistics provided by the Communicable Disease Control Center of the United States Public Health Service reveal that immunization levels against measles and poliomyelitis have fallen dangerously low as witnessed that only 50 per cent of poor children ages 1-4 years living in urban areas have received poliomyelitis immunizations and there is a danger of polio epidemics in certain areas; and

WHEREAS, There is a forecast of a rubella epidemic for the early 1970's - a disease which can cause serious birth defects if the mother becomes infected early in her pregnancy and only 21.2 million of a potential 60 million children have been immunized against this disease; and

WHEREAS, Certain urban areas show a relatively low level of immunization against diphtheria, Now, Therefore, Be It

RESOLVED, By The American Legion in National Convention assembled in Houston, Texas, August 31-September 2, 1971, that it urges the fullest use of any licensed vaccine developed to combat communicable diseases; And Be It Further

RESOLVED, That local posts of The American Legion cooperate in all ways possible to stimulate local immunization programs so that children of every community may achieve the fullest protection from all communicable diseases; and Be It Further

RESOLVED, That sufficient public funds be provided so that all medically indigent children may have an opportunity to be afforded immunization against all communicable diseases, and Be It Finally

RESOLVED, That this resolution be forwarded to the various State Legislatures for appropriate legislation to be enacted to make it a statutory requirement for admission into public school systems that each child be given the immunization shot for the above diseases.

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National Convention
Houston, Texas
August 31-September 2, 1971

Resolution No. 103 (Pennsylvania)

Venereal Disease Control

WHEREAS, Venereal disease is out of control in the United States, it is the number one communicable disease and the number two killer among communicable diseases; and

WHEREAS, Syphilis and gonorrhea are diseases which constitute a threat to all the people of our Nation; and

WHEREAS, Neither of them can be eliminated permanently from any area without eliminating them from neighboring areas and from all areas of social interchange; and

WHEREAS, The cost of maintaining the victims of syphilitic insanity in tax-supported institutions is approximately $44 million per year, another $5 million is spent for aid to the syphilitic blind, expenditures that can be eliminated with the eradication of syphilis alone; Now, Therefore, Be It

RESOLVED, By The American Legion in National Convention assembled in Houston, Texas, August 31-September 2, 1971, that it again urge the President of the United States, the Secretary of Health, Education and Welfare, the Under-Secretary for Health and Scientific Affairs, and the Members of the United States Congress, to recognize that venereal disease control is rapidly deteriorating and that immediate and emergency measures must be taken to restore fiscal and manpower resources adequate to complete the eradication of syphilis and to effect the control of gonorrhea.

AMERICAN MEDICAL ASSOCIATION

April 21, 1972

The Honorable Edward M. Kennedy
United States Senate
Senate Labor and Public Welfare Committee
431 Old Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

Legislation pending before the Senate Labor and Public Welfare Committee would extend and amend the Communicable Disease Control Act and would establish a separate program for the prevention and control of venereal disease. We consider this legislation to be of extreme importance to the health of the American people.

Medicine, on the national, state, county, and community levels, has consistently worked to bring to their patients the benefits of advances in medical research and developments. The physicians of America and the Public Health Service have been partners in the fight against disease and in the campaign to eradicate contagion wherever it is found. As you may know, the AMA, in 1962, actively urged the Congress to enact the first Vaccination Assistance Act which was designed to provide encouragement and financial assistance to states and communities to undertake intensive vaccination programs for young children.

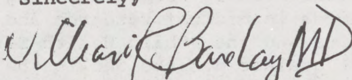
The Communicable Disease Control Act provides programs for control against venereal disease, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, and whooping cough. While this program has made substantial progress in reducing the incidence of these diseases, we are greatly concerned by reports which indicate declining levels of immunization protection against measles, poliomyelitis, and diphtheria in the United States. The 1970 United States Immunization Survey showed a substantially lower immunity level in preschool children in poverty areas against measles, poliomyelitis, diphtheria, tetanus, and whooping cough. Reports indicate threats of epidemic measles and poliomyelitis, especially in central city poverty areas and some rural areas, unless vigorous vaccination efforts are undertaken.

The spread of infectious venereal disease has already reached epidemic proportions. Gonorrhea is pandemic in the United States and has become the number one communicable disease. The Department of Health, Education, and Welfare recently estimated that there would be 2.5 million new cases of gonorrhea this year. Syphilis is the fourth most common communicable disease. It is evident that there is a high priority need for a national effort to control and eradicate venereal disease.

The progress which we have 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. However, it is clear to us, the physicians of America, that a great deal still can and must be done to bring under further control communicable disease. We believe that our national efforts to eradicate these dread diseases should be strengthened. We urge that support be provided for augmented programs of immunization and disease control.

Thank you for permitting us this opportunity to offer to you our views.

Sincerely,



William R. Barclay, M. D.
Assistant Executive
Vice President

WRB/pr

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS
211 EAST CHICAGO AVE., CHICAGO, ILL. 60611 PHONE (312) 943-8181

April 25, 1972

Honorable Edward M. Kennedy
United States Senate
Washington, D. C. 20510

Dear Senator Kennedy:

We commend your action to extend the authority for the Communicable Disease Control and Vaccination Assistance Act through the introduction of S. 3442. If effective control of communicable diseases is to be realized in this country, such legislative authority must not only exist, it must be implemented to its fullest extent.

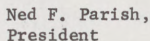
This has not been done. The Communicable Disease Control Amendments of 1970 which should have contributed to the control of these diseases were never fully implemented. And, according to the Chicago Board of Health, while we have the capability to immunize the population against communicable diseases such as measles, rubella and tuberculosis, there is no national plan for carrying out these immunizations.

Measles, the Board says, could be totally eradicated with proper immunization patterns. But, in 1970, the disease was contracted by 47,351 persons. Of these, 120 died. In 1971, the number of persons contracting measles increased to 75,045. While the incidences of mental retardation and other complications which can result from measles are difficult to pinpoint, they represent a side effect of a disease which should be and is not completely under control.

Rubella, or German measles, the Board reports, affected 56,552 persons in 1970, of which 77 died. While this number decreased in 1971 to 43,096, it could have been decreased by much more. Birth defects, such as blindness, deafness, and mental retardation resulting from this disease continue to be an unnecessary threat to the nation.

We support your efforts in this endeavor to control these and all other communicable diseases which are a serious health problem.

Sincerely,



Ned F. Parish,
President

NFP/jr

ADVANCING VOLUNTARY LEADERSHIP IN A CHANGING WORLD

Chamber of Commerce of the United States

LEGISLATIVE ACTION GENERAL MANAGER
HILTON DAVIS

202·659·6140

1615 H STREET, N.W.
WASHINGTON, D.C. 20006

May 10, 1972

Honorable Edward Kennedy, Chairman
Subcommittee on Health
Labor and Public Welfare Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The National Chamber appreciates this opportunity to present its views on Titles I and II of S.3419, a bill relating to consumer product safety, pending before your subcommittee.

Attached is a statement we submitted to the Senate Commerce Committee on S.983 and S.1797 on the same subject. In regard to the issues of coverage, structure and transfers of function, S.983 and S.1797 are substantially similar to S.3419. Therefore, our statement bears on your current deliberations, and we respectfully submit it for your consideration.

Concerning coverage, we oppose the Senate Commerce Committee's interpretation which would extend coverage to consumer products not "actually regulated". The phrase "subject to regulation" in Section 101 should be interpreted much more broadly, as discussed on page 7 of our attached statement.

Structure and the ancillary issue of transfers of function are dealt with on page 9 of our statement. We oppose the creation of a new independent Consumer Safety Agency, believing instead that the functions should be placed in the Department of Health, Education and Welfare.

We hope that the National Chamber's statement on Consumer Product Safety Legislation will be of assistance in your deliberations.

C O P Y

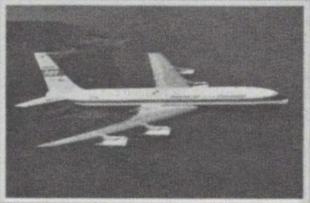
Cordially,

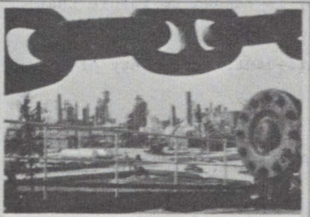
Hilton Davis

Hilton Davis
Legislative Action
General Manager

Enclosure

cc: Subcommittee members
LeRoy Goldman, Staff
Dr. Philip Caper, Staff
Stanley Jones, Staff





Statement of the

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA

on: S. 983 and S. 1797, Consumer Product Safety Legislation

to: Senate Commerce Committee

by: Kenneth F. Stinger

date: August 6, 1971

The Nation's largest business federation representing local and state chambers of commerce, trade and professional associations, and business firms

STATEMENT
on
S. 983 and S. 1797
CONSUMER PRODUCT SAFETY LEGISLATION
for submission to the
SENATE COMMERCE COMMITTEE
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
KENNETH F. STINGER*
August 6, 1971

The National Chamber appreciates this opportunity to present its views on two bills relating to consumer product safety pending before this committee.

We have serious reservations about S. 983 and believe that there are inadequacies in S. 1797. Of the two, however, S. 1797 clearly takes the preferable approach.

As the world's largest federation of business enterprises, the National Chamber has a strong interest in assuring that the consumer's right to safety is fully honored in our nation's marketplace. We believe that fairly protected and informed customers are essential to our private enterprise system. Indeed, we share with the committee the desire to extend fair protection in the consumer product safety area. The American consumer has the right to have his health and safety considered throughout the process for producing and distributing consumer products.

Most reprehensible are those few operators who throw caution to the wind and intentionally market products with no consideration of consumer safety. These operators not only injure and maim the American consumer, they also defile the marketplace and the overwhelming majority of ethical businessmen who make a constant and diligent effort to discover and eliminate from their products all substantial risks of injury.

We agree, too, that additional Federal authority is needed to insure that the consumer's right to safety is even more thoroughly considered by producers and distributors. While voluntary action has been significant, the safety of

* Executive, Consumer Affairs Committee, Chamber of Commerce of the United States

consumers is of such immense importance that a continuing Federal program of standards making and review is justified.

Therefore, we support the principle of legislation providing for the development of mandatory safety standards for those products presenting an unreasonable risk of death or personal injury to consumers, and establishing an equitable methodology for the prompt removal of unsafe products from the marketplace when imminent and extraordinary threats to consumer safety are posed.

In developing the necessary legislation we urge this committee and the Congress to be guided most of all by one overriding principle: that consumer product safety is the joint responsibility of business, government, and the consumer; and that none acting alone can prevent the majority of consumer product related hazards.

The business community has a threefold responsibility in this field. First, consumer safety must always be considered in the design, manufacture and sale of consumer products so as to provide affordable protection against foreseeable unreasonable hazards. This responsbility includes the continued development of voluntary safety standards. Second, the business community must disseminate important safety information to the consumer. Third, we must continue voluntarily to establish early warning and technical review systems whereby initially unrecognized safety defects may be discovered and eliminated as quickly as possible.

Maximum results can be achieved from legislation in this area only if it is designed to complement and reinforce the unique strengths and responsibilities of the business community. If a legislative solution unduly obstructs the free interchange of public demand and business innovation, genuinely imaginative solutions to consumer product safety problems are not likely to be found.

MAJOR ISSUES

Two very comprehensive consumer product safety proposals are presently pending before the Senate Commerce Committee. The first is S. 983 introduced by Senators Magnuson and Moss which embodies the recommendations of the now defunct National Commission on Product Safety. The second is S. 1797 introduced by Senators Magnuson and Cotton on behalf of the Administration.

A discussion of the major issues involved in each of these proposals follows. Some important miscellaneous issues and the difficult problem of deciding

how the consumer product safety function ought to be organized is discussed later.

Safety Standards Making Process

Three objectives must be accomplished in the creation of a new consumer product safety standards making process: (1) establishment of a competent methodology for determining the need for a safety standard, (2) institution of a competent system for developing technically relevant safety standards, and (3) development of sound procedures which will insure due process of law while eliminating unduly protracted proceedings. None of these factors can be ignored if the process envisioned in S. 983 and S. 1797 is to function effectively.

Meeting the first two objectives requires maximum feasible consultation with those most expert in the design, manufacture and distribution of the consumer products subjected to the safety standards making process. The Administration's proposal, S. 1797, more nearly fulfills the first two objectives by providing a significant role for the nation's private standards making organizations -- the institutions that possess the required expertise. Especially commendable are provisions in S. 1797 permitting the adoption of existing private safety standards if they are found to be adequate.

But, neither S. 983 nor S. 1797 go far enough in meeting the first objective of establishing a competent methodology for determining if a consumer product safety standard is necessary. We offer two suggestions to correct this deficiency.

First, provide for a streamlined hearing on only those facts which are disputed and material. Second, adopt a clearer definition of the economic factors which must be considered prior to deciding the need for a safety standard -- clearer than what now appears in Section 9 (c) of S. 1797.

Both of these amendments are vitally important because they relate to the critical question of whether, in a specific case, the standards making process ought to be invoked. It is at this stage that the trivial, or the less important, questions must be filtered out. The resources of the standards formulating body must be focused on achievable and important goals if it is to succeed.

The third objective requires the Congress to strike a realistic balance between the need for an efficient standards making process and our constitutional guarantees of procedural due process. S. 1797 takes a generally more balanced approach to this than S. 983 by requiring use of the formal protections in the

Administrative Procedure Act. The latter uses wherever possible the informal rulemaking provisions of that Act. The more formal procedures we propose would provide for the development of fair standards based on a public record after an agency hearing on the disputed facts, and so preserve due process of law.

With these suggested amendments, we generally support the standards-making approach of S. 1797, i.e., authorizing the development of safety standards when they are needed to reduce or eliminate an unreasonable risk of death or of serious or frequent illness or injury.

Hazardous Products

We believe that the governmental institution administering a new product safety program should have the power to seek appropriate, equitable court relief against the marketing of consumer products which pose an imminent and extraordinary threat to consumer safety. Our courts are uniquely qualified to fashion such remedies in the light of the facts of the particular case.

Unfortunately, S. 983 would permit the Consumer Product Safety Commission to ban products on its own initiative and without an impartial review as provided by the courts in dealing with these important questions. Certainly, the short time required to apply to the Federal courts for an appropriate equitable order is not such a delay as to require a sweeping negation of an essentially judicial function. Generally, the approach of S. 1797 is preferable, in that the court's expertise in these matters would be used.

But S. 1797 contains a dangerous overlap between Sections 9 (e) on Ban of Products, and 12 on Imminent Hazards, although the standards for action under these sections differ. Certainly, Section 12 could be used to obtain a court order banning an imminently hazardous product from commerce in as efficient a manner as a banning action under Section 9 (e). We believe that Section 9 (e) -- if at all necessary in view of Section 12 -- should be amended to make the criteria for banning of a product identical to the standards in Section 12 on imminent hazards.

Information Development and Disclosure

New programs are needed for the development and dissemination of consumer product safety information. Non-confidential information held by other government agencies in the consumer safety area ought to be made available in a fair and equitable manner.

But the disclosure of such information must be made in accordance with realistic safeguards designed to prevent anti-competitive results. Meaningful protection must be provided for trade secrets and other confidential company information.

Moreover, the data released to consumers should not be inaccurate, misleading or incomplete. In this connection, the affected party must be given an opportunity to comment prior to the release -- unless extraordinary health and safety hazards dictate otherwise. Moreover, the affected party should have the right of retraction and updating when that proves necessary.

S. 983 provides no meaningful protection for trade secrets or confidential company information. Indeed, a simple determination under Section 19 (d) that disclosure of a trade secret is "necessary to carry out the purposes of the Act" would justify public release ... even if the Commission knew that a substantial anti-competitive effect could result. When linked to the Consumer Product Safety Commission's wide information-gathering powers, this empty standard is patently dangerous to our competitive system.

More acceptable is Section 4 (c) (1) of S. 1797. This section provides that trade secrets, formulas, processes, costs, methods of doing business, and other competitive information not generally available to the public could not be released. While much better, this provision still does not provide the degree of protection necessary.

We suggest that the committee look closely at the information disclosure provisions in Section 403 of S. 1177, the Federal consumer representation legislation. Similar provisions passed the Senate during the 91st Congress in S. 4459. It is most important that the information disclosure provisions of any bill reported by this committee closely parallel the language in that provision.

Enforcement of Safety Standards: Recall, Repair or Refund

We support the concept that violations of Federal safety standards should be redressable in the courts upon petition by the involved administrative body. Appropriate civil penalties should be assessed against violators.

But we hasten to add that unless meaningful standards for enforcement of product safety orders are set by the Congress, it is entirely possible that

resources will be wasted prosecuting trivial or insignificant technical violations.

The committee should look at Section 13 of H.R. 8110, the House version of the Administration's bill. That section contains language requiring a hearing for determining the significance of a violation of a safety order before more involved action may be taken. To be actionable, there must be a determination based on the hearing that the failure to comply with the safety order creates a "significant risk of death, illness or injury to any person."

Additionally, it is entirely possible that, in some cases, the appropriate civil penalty could involve a refund or the replacement of a consumer product. But under S. 983, a consumer could gain a windfall through use of a product for a substantial amount of time, by claiming a full refund for violation of a safety standard. We support correction of this inequity as in S. 1797 by incorporating language permitting the deduction of reasonable depreciation for use of the product from total liability for refund or replacement after a safety standard failure or violation.

We have very strong reservations about the inclusion of separate seizure provisions in any consumer product safety law. Seizure is a very punitive action and should be imposed only in those extreme situations proven in a court of law.

Even more unfortunate is the fact that S. 1797, in Section 16 (c), provides for seizure without even a determination of the significance of the risk to consumer safety involved. No standards are included in the subsection. Indeed, if the risk to consumer safety is great, seizure could be effected through a court petition under Section 12 of S. 1797 on imminent hazards. Section 12 (b) specifically mentions seizure of a product as an alternative to notification, recall, repair or replacement and the powers in that section are ample protection for the public.

With the suggested modifications mentioned above, we support generally the approach of S. 1797 on penalties for failure to comply with a safety standard or order.

<u>Federal-State Relations</u>

Neither S. 1797 nor S. 983 provides a meaningful solution to the chaotic situation which exists nationwide due to the confusing and often conflicting Federal, state, and local consumer product safety requirements. The report of the

National Commission on Product Safety documents the vast discrepancies now present in state and local safety programs.

Both bills provide for a general Federal pre-emption of less stringent state and local safety standards. This approach, of course, leaves completely untouched the morass of conflicting and confusing state and local regulations imposing more stringent requirements, which would be institutionalized through the special application procedure provided in both bills.

This committee should adopt a provision establishing complete uniformity of safety standards -- with exceptions thereto Federally determined and based only on local geographic and climatic considerations.

Adoption of such a provision could raise significantly the level of safety standard compliance nationwide. Businessmen across the nation at last would be able to determine with specificity the safety requirements imposed.

Coverage

S. 983 would provide the Consumer Product Safety Commission with authority to regulate any consumer product not now actually subject to Federal regulation; S. 1797 would exempt from coverage those which may now be regulated under existing Federal safety law.

The difference is significant both in terms of the jurisdiction and workloads of the Federal agencies. Certainly, if the consumer product safety problem is as widespread as the report of the National Commission on Product Safety would have us believe, then any new safety program would have a full agenda without infringing upon the jurisdiction of other Federal agencies working in the consumer safety area.

We support the Administration's approach to this matter. S. 1797's provision has the merit of focusing the new consumer safety program on achievable objectives in need of safety regulation review, of eliminating interagency friction, and of permitting a new, specific safety expertise to be created for those items not now subject to regulation. Indeed, the Administration bill's approach insures that a single product will not be subjected to diverse and possibly conflicting regulatory policies.

OTHER ISSUES

The Administration bill contains two other provisions with seriously

inadequate standards for implementation. The first is in Section 9 (d) (1) regarding the characteristics and limitations of product safety performance standards. The standard cited -- "if the Secretary determines such application to be in the public interest" -- is vague. A similarly inadequate standard appears in Section 14 (b) on recordkeeping. More specific and meaningful standards in both cases are necessary if any guidance for administrative action is to be provided.

The authorization in S. 983 for the design, construction, and operation of costly new product testing facilities is unfortunate. Much more realistic and efficient a solution to necessary testing is provided in S. 1797. There, the existing testing facilities, personnel, and technical resources of the other Federal agencies are made to serve the new program.

We agree with the testimony of the National Safety Council that there is a woeful lack of reliable data on accidents and injuries. Both S. 983 and S. 1797 would provide for the collection, evaluation, and dissemination of information on the frequency and causes of death or injury and for the development of means to evaluate risks. These are meritorious.

We support establishment of an injury information clearinghouse. A number one priority should be the development of reliable means for determining whether a specific injury is product-caused, consumer-caused, or both.

Regarding the application of safety standards to consumer products for export and import, we endorse the Administration bill's general approach of providing for exemptions from domestic safety standards for consumer goods if prominently labeled "for export." We believe that the export provisions in S. 983 would place U. S. firms at a distinct competitive disadvantage abroad, by requiring as a practical matter that they meet our domestic safety standards as well as all applicable foreign safety standards. Imported goods should be required to meet our domestic safety standards.

The inspection provisions of both S. 983 and S. 1797 provide little consideration for necessary industrial privacy. We believe that an equally effective inspection program could be had by adapting the language of the existing provisions of the X-radiation law to the consumer product safety area.

Both S. 1797 and S. 983 have provisions for judicial review of Federal safety standards. The language of S. 1797, which affords this right to persons "adversely affected" is preferable to the wording of S. 983. Under S. 1797 the question whether a specific consumer is a person "adversely affected" would be

determined by the courts on the basis of the large body of judicial precedents on standing to bring an action. We also note with approval the more meaningful review standards of S. 1797, requiring the agency to support its action by "substantial evidence based on the record as a whole" rather than the arbitrary and capricious standard in S. 983.

STRUCTURE

The decision as to how the consumer product safety program should be organized must be based on a determination of what location will provide the most expertise and resources for efficient implementation of the legislation's objectives. We are convinced that of the alternatives before the committee, assignment of the function to a new Consumer Safety Administration within the Department of Health, Education and Welfare most ably meets these criteria.

We think that the type of structure referred to in testimony by Secretary Elliot L. Richardson would substantially enlarge HEW's strength in the consumer protection area. Additionally, HEW's extensive field enforcement staff, medical and technical experts, and testing laboratories would bring instant efficiency in the administration of a new Product Safety Act. We do not believe that costly duplication of these functions in a new independent agency is in the public interest.

CONCLUSION

The National Chamber agrees that there is a need for Federal legislation providing for the development of mandatory consumer product safety standards. For instances of extraordinary and imminent risks, the Chamber supports quick injunctive court action to prevent serious injury to consumers. Additionally, there is a real need for a Federal injury data collection center that could provide documented information regarding the causes of consumer product injury. For until we can be sure of the relationship of consumer products and product related injuries we cannot rationally reduce the incidence of injury.

Generally, the National Chamber endorses the approach of the Administration bill, S. 1797, which would create a strong new product safety program within the Department of Health, Education and Welfare. Our major reservations to the Administration approach relate to the workings of the standards making mechanism -- especially concerning the determination of need for a safety standard, the inadequacy of standards for action as already noted, the unnecessary duplication of seizure provisions, the need for better protections for confidential company data and trade secrets, and to other matters detailed in this statement. We also support nationwide uniformity in state and local safety requirements, and more reasonable inspection and recordkeeping programs.

Senator EAGLETON. That concludes the hearings on S. 3342. The committee will be adjourned.

(At 1 p.m., the committee was adjourned.)

APPENDIX I

Calendar No. 791

92D CONGRESS
2D SESSION

S. 3442

[Report No. 92–825]

IN THE SENATE OF THE UNITED STATES

MARCH 29, 1972

Mr. KENNEDY (for himself, Mr. CRANSTON, Mr. DOMINICK, Mr. EAGLETON, Mr. HUGHES, Mr. JAVITS, Mr. MONDALE, Mr. PELL, Mr. RANDOLPH, Mr. SCHWEIKER, Mr. STEVENSON, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

JUNE 1, 1972

Reported by Mr. KENNEDY, with an amendment

[Strike out all after the enacting clause and insert the part printed in italic]

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*

2 *tives of the United States of America in Congress assembled,*

3 ~~That this Act may be cited as the "Communicable Disease~~

4 ~~Control Amendments Act of 1972".~~

5 ~~SEC. 2. (a) Section 317(a) of the Public Health Serv-~~

6 ~~ice Act is amended to read as follows: "There are authorized~~

7 ~~to be appropriated $90,000,000 for the fiscal year ending~~

II

1 ~~June 30, 1972; $90,000,000 for the fiscal year ending June~~
2 ~~30, 1973, and each of the next four succeeding fiscal years~~
3 ~~to enacle the Secretary to make grants to States, and in~~
4 ~~consultation with the State health authority to agencies and~~
5 ~~political subdivisions of the States, under this subsection. In~~
6 ~~the awarding of such grants, the Secretary shall give con-~~
7 ~~sideration to the relative extent of the problems relating to~~
8 ~~one or more of the diseases referred to in subsection (b) (1)~~
9 ~~and to the design of the public health program to assure~~
10 ~~effective performance in preventing and controlling such~~
11 ~~diseases. Such grants may be used for meeting the cost of~~
12 ~~communicable disease control programs and their attendant~~
13 ~~laboratory services, including the cost of studies to determine~~
14 ~~the communicable disease control needs of the communities~~
15 ~~and the best means of meeting such needs.~~
16 ~~(b) (1) Subsection (b) of such section is amended by~~
17 ~~striking out the word "subsection" and inserting in lieu~~
18 ~~thereof "section".~~
19 ~~(2) Subsection (b) (1) of such section is amended by~~
20 ~~striking out the phrase "on the recommendation of the Na-~~
21 ~~tional Advisory Health Council".~~
22 ~~(c) Such section, as amended by this Act, is further~~
23 ~~amended by adding at the end thereof the following new~~
24 ~~subsection:~~
25 ~~"(h) (1) The Secretary is authorized to make grants~~

~~to, and enter into contracts with, public and private nonprofit agencies, organizations and institutions for the purpose of making the citizens of the United States aware of the consequences of the diseases described in subsection (b) (1) and the programs available which will avert such consequences.~~

~~(2) For the purpose of carrying out this subsection, there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1973, and each of the next four succeeding fiscal years."~~

That this Act may be cited as the "Communicable Disease Control Amendments Act of 1972".

TITLE I—COMMUNICABLE DISEASE PREVENTION AND CONTROL

SEC. 101. (a) Section 317(a) of the Public Health Service Act is amended to read as follows: "There are authorized to be appropriated $90,000,000 for the fiscal year ending June 30, 1972; $90,000,000 for the fiscal year ending June 30, 1973, and each of the next four succeeding fiscal years to enable the Secretary to make grants to States, and in consultation with the State health authority, to agencies and political subdivisions of the States, under this subsection. In the awarding of such grants, the Secretary shall give consideration to the relative extent of the problems relating to one or more of the diseases referred to in sub-

1 *section (b)(1) and to the design of the public health pro-*
2 *gram to assure effective performance in preventing and*
3 *controlling such diseases. Such grants may be used for meet-*
4 *ing the cost of communicable disease control programs and*
5 *their attendant laboratory services, including the cost of*
6 *studies to determine the communicable disease control needs*
7 *of the communities and the best means of meeting such needs.*
8 *(b)(1) Subsection (b) of such section is amended by*
9 *striking out the word "subsection" and inserting in lieu*
10 *thereof "section".*
11 *(2) Subsection (b)(1) of such section is amended by*
12 *striking out the phrase "on the recommendation of the Na-*
13 *tional Advisory Health Council".*
14 *(c) Subsection (f) of such section is amended by strik-*
15 *ing "assisted under this section".*
16 *(d) Such section, as amended by this Act, is further*
17 *amended by adding at the end thereof the following new*
18 *subsections:*
19 *"(h)(1) The Secretary is authorized to make grants*
20 *to, and enter into contracts with, public and private non-*
21 *profit agencies, organizations, and institutions for the pur-*
22 *pose of making the citizens of the United States aware of*
23 *the consequences of the diseases described in subsection*
24 *(b)(1) and the programs available which will avert such*
25 *consequences.*

1 *"(2) For the purpose of carrying out this subsection,*
2 *there are authorized to be appropriated $5,000,000 for the*
3 *fiscal year ending June 30, 1973, and each of the next four*
4 *succeeding fiscal years.*
5 *"(i) Except for section 318 of this Act, notwithstanding*
6 *any other provision of law unless enacted after the enactment*
7 *of this Act expressly in limitation of this section, no funds*
8 *appropriated pursuant to the authorization of any section of*
9 *the Public Health Service Act other than this section shall be*
10 *available for communicable disease control or vaccination*
11 *assistance programs of the type authorized under this section."*
12 *SEC. 102. Section 314(e) of such Act is amended by*
13 *striking "$157,000,000" and inserting in lieu thereof*
14 *"$179,000,000."*
15 *SEC. 103. Section 1001(c) of the Public Health Service*
16 *Act is amended by striking out "$90,000,000" and inserting*
17 *"$127,300,000" in lieu thereof.*
18 *TITLE II—VENEREAL DISEASE PREVEN-*
19 *TION AND CONTROL*
20 *SEC. 201. This title may be cited as the "National Vene-*
21 *real Disease Prevention and Control Act".*
22 *SEC. 202. (a) The Congress finds and declares that—*
23 *(1) the number of reported cases of venereal disease*
24 *has reached epidemic proportions in the United States;*
25 *(2) the number of patients with venereal disease*

1 *reported to public health authorities is only a fraction*
2 *of those treated by physicians;*
3 *(3) the incidence of venereal disease is particu-*
4 *larly high among individuals in the 20–24 age group,*
5 *and in metropolitan areas;*
6 *(4) venereal disease accounts for needless deaths*
7 *and leads to such severe disabilities as sterility, insanity,*
8 *blindness, and crippling conditions;*
9 *(5) the number of cases of congenital syphilis,*
10 *a preventable disease, in infants under one year of age*
11 *increased by $33\frac{1}{3}$ per centum between 1970 and 1971;*
12 *(6) health education programs in schools and*
13 *through the mass media may prevent a substantial por-*
14 *tion of the venereal disease problem; and*
15 *(7) medical authorities have no successful vac-*
16 *cine for syphilis or gonorrhea and no blood test for the*
17 *detection of gonorrhea among the large reservoir of*
18 *asymptomatic females.*
19 *(b) In order to preserve and protect the health and*
20 *welfare of all citizens, it is the purpose of this Act to estab-*
21 *lish a national program for the prevention and control of*
22 *venereal disease.*
23 *AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT*
24 *SEC. 203. (a) Part B of title III of the Public Health*
25 *Service Act is amended by adding immediately after section*
26 *317 thereof the following new section:*

1 "*PROJECTS AND PROGRAMS FOR THE PREVENTION AND*
2 *CONTROL OF VENEREAL DISEASE*

3 "*SEC. 318. (a) The Secretary is authorized to conduct,*
4 *and render assistance to appropriate public authorities and*
5 *scientific institutions in the conduct of research, training, and*
6 *public health programs relating to the prevention and control*
7 *of venereal disease.*
8 "*(b)(1) The Secretary is authorized to make grants to*
9 *States, political subdivisions, universities, hospitals, and other*
10 *public or nonprofit private institutions, agencies, institutions,*
11 *or organizations, for projects for the conduct of research,*
12 *demonstrations, or training for the prevention or control of*
13 *venereal disease.*
14 "*(2) For the purpose of carrying out this subsection,*
15 *there is authorized to be appropriated the sum of $15,000,000*
16 *for the fiscal year ending June 30, 1973, and for each of the*
17 *next two succeeding fiscal years.*
18 "*(c)(1) There is authorized to be appropriated the*
19 *sum of $30,000,000 for the fiscal year ending June 30,*
20 *1973, and for each of the next two succeeding fiscal years,*
21 *to enable the Secretary to make grants to State health au-*
22 *thorities to assist the States in establishing and maintaining*
23 *adequate public health programs for the diagnosis and treat-*
24 *ment of venereal disease. The sums so appropriated shall be*
25 *used for making payments to States which have submitted,*

1 *and had approved by the Secretary, State plans for the pro-*
2 *vision of public health services for the diagnosis and treat-*
3 *ment of venereal disease.*
4 *"(2) In order to be approved under this subsection, a*
5 *State plan for the provision of public health services for the*
6 *diagnosis and treatment of venereal disease must—*
7 *"(A) provide for the administration or supervision*
8 *of administration by the State health authority;*
9 *"(B) set forth the policies and procedures to be*
10 *followed in the expenditure of the funds paid to the*
11 *State under this subsection;*
12 *"(C) provide that the public health services fur-*
13 *nished under the plan will include the provision of state-*
14 *wide laboratory services which include Darkfield micro-*
15 *scopes for the diagnosis of both gonorrhea and syphilis,*
16 *and will otherwise be in accordance with standards pre-*
17 *scribed by regulations, including standards as to the scope*
18 *and quality of such services;*
19 *"(D) contain or be supported by assurances satis-*
20 *factory to the Secretary that (i) the funds paid to the*
21 *State under this subsection will be used to make a sig-*
22 *nificant contribution toward providing and strengthen-*
23 *ing public health services for the diagnosis and treat-*
24 *ment of venereal disease in the various political subdivi-*
25 *sions in order to improve the health of the people; (ii)*

1 *such funds will be used to supplement and, to the extent*
2 *practical, to increase the level of funds that would other-*
3 *wise be made available for the purposes for which the*
4 *Federal funds are provided and not to supplant any non-*
5 *Federal funds which would otherwise be available for*
6 *such purpose; and (iii) the plan is compatible with the*
7 *total health program of the State;*
8 *"(E) provide that the State health authority will*
9 *from time to time, but not less often than annually, re-*
10 *view and evaluate its State plan approved under this*
11 *subsection, and submit to the Secretary appropriate*
12 *modifications thereof;*
13 *"(F) provide that the State health authority will*
14 *make such reports, in such form and containing such in-*
15 *formation, as the Secretary may from time to time*
16 *reasonably require, and will keep such records and afford*
17 *such access thereto as the Secretary finds necessary to*
18 *assure the correctness and verification of such reports;*
19 *"(G) provide for such fiscal control and fund ac-*
20 *counting procedures as may be necessary to assure the*
21 *proper disbursement of and accounting for funds paid to*
22 *the State under this subsection; and*
23 *"(H) contain such additional information and as-*
24 *surances as the Secretary may find necessary to carry*
25 *out the purposes of this subsection.*

1 *"(3) From the sums appropriated to carry out the pro-*
2 *visions of this subsection, the several States shall be entitled*
3 *for each fiscal year to allotments determined, in accordance*
4 *with regulations, on the basis of the incidence of venereal*
5 *disease in, and the population of, the respective States; ex-*
6 *cept that no State's allotment shall be less than $75,000 for*
7 *any fiscal year.*
8 *"(4)(A) From each State's allotment under this sub-*
9 *section for a fiscal year, the State shall be paid a Federal*
10 *share of the expenditures incurred during such year under its*
11 *State plan approved under this subsection. Such payments*
12 *shall be made from time to time in advance on the basis of*
13 *estimates by the Secretary or by way of reimbursement,*
14 *with necessary adjustments on account of previous under-*
15 *payments or overpayments.*
16 *"(B) The Federal share for any State shall be such*
17 *per centum (not in excess of 90 per centum) of the expendi-*
18 *tures of such State (referred to in subparagraph (A)) as*
19 *shall be established by such State.*
20 *"(C) 'State' means each of the several States of the*
21 *United States, the District of Columbia, the Virgin Islands,*
22 *Guam, American Samoa, Trust Territory of the Pacific*
23 *Islands, and the Commonwealth of Puerto Rico.*
24 *"(D) Any amount so allotted to a State during any such*
25 *fiscal year (other than the Virgin Islands, American Samoa,*

1 *Guam, the Trust Territory of the Pacific Islands, and the*
2 *Commonwealth of Puerto Rico) and remaining unobligated*
3 *at the end of such year shall remain available to such State,*
4 *for the purposes for which made, for the next fiscal year*
5 *(and for such year only) and any such amount shall be in*
6 *addition to the amounts allotted to such State for such pur-*
7 *pose for such next fiscal year; except that any such amount*
8 *remaining unobligated at the end of the sixth month follow-*
9 *ing the end of such year for which it was allotted which*
10 *the Secretary determines will remain unobligated by the close*
11 *of such next fiscal year may be reallotted by the Secretary,*
12 *to be available for the purposes for which made until the*
13 *close of such next fiscal year, to other States which have*
14 *need therefor, on such basis as the Secretary deems equitable*
15 *and consistent with the purposes of this subsection, and any*
16 *amount so reallotted to a State shall be in addition to the*
17 *amounts allotted and available to the States for the same*
18 *period. Any amount allotted under this subsection of this*
19 *section to the Virgin Islands, American Samoa, Guam, the*
20 *Trust Territory of the Pacific Islands, or the Commonwealth*
21 *of Puerto Rico for a fiscal year and remaining unobligated*
22 *at the end of such year shall remain available to it for the*
23 *purposes for which made, for the next two fiscal years (and*
24 *for such years only), and any such amount shall be in addi-*
25 *tion to the amounts allotted to it for such purpose for each of*

1 *such next two fiscal years; except that any such amount, re-*
2 *maining unobligated at the end of the first of such next two*
3 *years, which the Secretary determines will remain unobli-*
4 *gated at the close of the second of such next two years,*
5 *may be reallotted by the Secretary, to be available for the*
6 *purposes for which made until the close of the second of*
7 *such next two years, to any other of such named States which*
8 *have need therefor, on such basis as the Secretary deems*
9 *equitable and consistent with the purposes of this part, and*
10 *any amount so reallotted to any such named State shall be*
11 *in addition to any other amounts allotted and available to it*
12 *for the same period.*
13 *"(5) Effective with respect to allotments under this sub-*
14 *section at least 70 per centum of a State's allotment under*
15 *this subsection shall be available only for the provision under*
16 *the State plan of services in communities of the State.*
17 *"(d) (1) The Secretary is authorized to make project*
18 *grants to States and, in consultation with the State health*
19 *authority, to political subdivisions of States, for the conduct*
20 *of venereal disease prevention and control programs.*
21 *"(2) For purposes of this subsection, the term 'vene-*
22 *real disease prevention and control program' means a pro-*
23 *gram which includes—*
24 *"(A) disease surveillance activities, including the*
25 *reporting, screening, and followup of diagnostic tests*
26 *and diagnosed cases of venereal disease;*

1 "(B) casefinding and case followup activities,
2 including contact tracing of infectious cases;
3 "(C) interstate epidemiologic referral and follow-
4 up activities;
5 "(D) professional and public venereal disease edu-
6 cation activities; and
7 "(E) such special studies or demonstrations to
8 evaluate or test venereal disease control as may be pre-
9 scribed by the Secretary.
10 "(e) Grants made under subsection (b) or (d) of
11 this section shall be made on such terms and conditions as
12 the Secretary finds necessary to carry out the purposes of
13 such subsection, and payments under any such grants shall
14 be made in advance or by way of reimbursement and in such
15 installments as the Secretary finds necessary.
16 "(f) Nothing in this section shall be construed to limit
17 or otherwise restrict the use or availability of funds which
18 are granted to a State or to a political subdivision of a State
19 under other provisions of section 317 of this Act which are
20 available for the conduct of venereal disease programs from
21 being used in connection with programs assisted through
22 grants under this section.
23 "(g) For the purpose of carrying out this subsection,
24 there is authorized to be appropriated the sum of $30,000,-
25 000 for the fiscal year ending June 30, 1973, and for each
26 of the next two succeeding fiscal years.

1 *"(h) Each recipient of assistance under this section*
2 *shall keep such records as the Secretary shall prescribe, in-*
3 *cluding records which fully disclose the amount and disposi-*
4 *tion by such recipient of the proceeds of such assistance, the*
5 *total cost of the project or undertaking in connection with*
6 *which such assistance is given or used, and the amount of*
7 *that portion of the cost of the project or undertaking sup-*
8 *plied by other sources, and such other records as will facili-*
9 *tate an effective audit.*
10 *"(i) The Secretary and the Comptroller General of the*
11 *United States, or any of their duly authorized representa-*
12 *tives, shall have access for the purpose of audit and examina-*
13 *tion to any books, documents, papers, and records of the re-*
14 *cipients that are pertinent to the assistance received under*
15 *this section.*
16 *"(j) The Secretary, at the request of a recipient of a*
17 *grant under this section, may reduce such grant by the fair*
18 *market value of any supplies, or equipment furnished to such*
19 *recipient and by the amount of pay, allowances, traveling*
20 *expenses, and any other costs in connection with the detail*
21 *of an officer or employee to the recipient when the furnish-*
22 *ing of such supplies or equipment, or the detail of such officer*
23 *or employee (as the case may be), is for the convenience of*
24 *and at the request of such recipient and for the purpose of*
25 *carrying out the program with respect to which the grant*

1 *under this section is made. The amount by which any such*
2 *grant is so reduced shall be available for payment by the*
3 *Secretary of the costs incurred in furnishing the supplies,*
4 *equipment, or personal services on which the reduction of*
5 *such grant is based, but such amount shall be deemed a part*
6 *of the grant to such recipient and shall, for the purposes of*
7 *this section, be deemed to have been paid to such agency.*
8 *"(k) Any grant awarded pursuant to this section shall*
9 *be subject to the condition that all information obtained by*
10 *the personnel of the project from participants in the project*
11 *related to their examination, care, and treatment, shall be*
12 *held confidential, and shall not be divulged without the indi-*
13 *vidual's consent except as may be necessary to provide service*
14 *to the individual. Information may be disclosed in summary,*
15 *statistical, or other form or for clinical and research purposes*
16 *in such a way as not to identify particular individuals."*

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APPENDIX II

Calendar No. 791

92D CONGRESS
2d Session

SENATE

REPORT
No. 92–825

COMMUNICABLE DISEASE CONTROL AMENDMENTS ACT OF 1972

JUNE 1, 1972.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Public Welfare, submitted the following

REPORT

[To accompany S. 3442]

The Committee on Labor and Public Welfare, to which was referred the bill (S. 3442) to amend the Public Health Service Act to extend the authorization for grants for communicable disease control and vaccination assistance and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

I. SUMMARY

TITLE I

The Committee's bill, The Communicable Disease Control and Vaccination Assistance Amendments of 1972, would authorize a five-year program of project grants to maintain a federal commitment to State and local governments for assistance in programs for the prevention and control of communicable diseases. Such diseases affect millions of Americans each year and especially present a serious threat to the health of the Nation's children, a most vulnerable population. Communicable diseases know no geographic boundaries and the threat which they pose is needless. This Nation has the medical skill and knowledge to prevent or control illness resulting from communicable diseases.

Ninety million dollars is authorized to be appropriated for each of the next five fiscal years to enable the Secretary to make grants to States and in consultation with the State Health Authority, to agencies and political subdivisions of the States. In making these awards, the Secretary shall give consideration to the relative extent of communicable disease and vaccination problems and to the design of the public

health program to insure effective performance in preventing and controlling such diseases. Grants may be used to meet the cost of such programs, including the costs of attendant laboratory services and studies to determine program needs and the best means to meet the need. The diseases to be combatted include tuberculosis, venereal disease, rubella, measles, poliomyelitis, diphtheria, tetanus, whooping cough, and RH disease.

Because of the serious need for greater public awareness regarding communicable diseases and programs available to treat them, the bill also provides for a new authorization of $5 million a year for the next five fiscal years for such purposes.

Title I of S. 3442 also increases for the next fiscal year levels of authorization for section 314(e) and section 1001(c) of the Public Health Service Act as requested by the Administration.

A new provision limits funding for such communicable disease programs as authorized under this bill to the legislative authorities encompassed by the bill, namely sections 317 and 318 of the Public Health Service Act. This provision emphasizes the need for a categorical authority to develop long-term planning and a national commitment to focus on programs to combat and prevent communicable diseases.

TITLE II

Title II of S. 3442 creates a new section 318 of the Public Health Service Act to provide a specially targeted program for venereal disease prevention, control, diagnosis, and treatment.

This title reflects the increasing concern that intervention is imperative to meet a venereal disease crisis, currently reaching epidemic proportions. To meet the health care crisis represented by the widespread threat of venereal disease, Title II of S. 3442 amends the Public Health Service Act to create a new section 318 by authorizing a three-year program for research, training and public health programs in the prevention and control of venereal disease. For research, training and public health projects relating to the prevention and control of venereal disease, $15 million is authorized for each of the next three fiscal years.

To meet the needs for effective diagnosis and treatment of venereal disease, $30 million is authorized for each of the next three fiscal years. $30 million for project grants to states and cities to conduct defined comprehensive prevention and control programs is also provided for each of the next three succeeding fiscal years.

II. Hearings

The need for the extension of the authority contained in section 317 of the Public Health Service Act in respect to communicable diseases and the need for a special authority in respect to venereal disease control was supported by testimony from James R. Kimmey, M.D., of the American Public Health Association; Samuel L. Katz, M.D., of the American Academy of Pediatrics; Bruce Webster, M.D., and John Hume, M.D., of the American Social Health Association; Leo Reichman, M.D., of the New York City Department of Health; William Schaffner, M.D., of the Action Committee for Child-

hood Immunization; Robert J. Anderson, M.D., of the National Tuberculosis and Respiratory Disease Association; and Mack I. Shanholtz, M.D., of the Virginia Department of Health. The Administration recommended against the enactment of both titles I and II of the Committee's bill.

III. Background

The impact of communicable disease control on our nation's history is perhaps nowhere better defined than in the conquest of poliomyelitis. A generation of young Americans now exist to which the term, "infantile paralysis," is essentially meaningless; yet less than two decades ago the annual arrival of summer brought to America's parents a sombre fear of the predictable epidemics of polio about to begin.

Only slightly less dramatic have been the changes wrought by controlling tuberculosis, diphtheria, and measles, and by preventing the devastating late sequelae of syphilis.

As a result of communicable disease control activities, communicable diseases have long since given way to chronic degenerative diseases as major causes of death in the United States. However, the efforts to control communicable diseases in this country have also brought with them repeated lessons in the harsh reality that without persisting vigilance, communicable disease control is a sometime thing. In the late 50's following curtailment of assistance provided under the Poliomyelitis Vaccination Assistance Act of 1955 (extended through 1957) epidemics appeared in Providence, Chicago, and Detroit, taking a needless toll among the urban poor. A special appropriation of one million dollars in May 1960 was necessary to provide oral polio vaccine for purposes of controlling epidemics. The apparent need to continue support for polio prevention led to passage of the Vaccination Assistance Act of 1962 which provided funds to combat poliomyelitis, whooping cought, diphtheria, tetanus and when an effective vaccine became available, measles. The subsequent years constituted a "Golden Age" of gains against diseases preventable by immunization. But on June 30, 1968 the Vaccination Assistance Act expired and funds appropriated under that legislation were exhausted in 1969. The incidence of measles resurged briskly in 1969 and 70 and in 1971 reached the highest level of incidence recorded since widespread use of measles vaccine began. Significant increases were also seen in the incidence of diphtheria and poliomyelitis. The epidemiological pattern of resurgence in all these diseases was remarkably similar to the earlier experience with poliomyelitis, to wit, the occurrence of outbreaks among the urban and rural poor who had not been afforded the protection of vaccination.

The history of syphilis control activities confirms the need for viewing communicable disease control as a long term commitment. Following World War II syphilis incidence fell sharply under the combined influences of the introduction of penicillin, and the availability of federal budget support for State and local V.D. control projects. With syphilis at an all time low level, close to elimination, federal support was sharply reduced from 1952 to 1955. In 1957, syphilis began to briskly resurge and increased steadily until 1965. Increased federal support for syphilis control activities, following the report of the Surgeon General's Task Force on the Eradication of Syphilis in 1961,

stimulated an intensified commitment against syphilis and again the incidence of the disease fell. However, with a stable budget during the early mid-60's, accompanied by increasing inflation, the available effective resources declined and syphilis is again increasing. The other major venereal disease, gonorrhea, until recently was never the target of a nationwide control program. Gonorrhea has dramatically increased and now constitutes a nationwide epidemic of immense proportions. Over 2½ million cases are estimated to have occurred last year in the United States.

In tuberculosis control, under the influence of federal project support, beginning in 1965 the incidence of new active cases fell at an increasingly rapid rate. More significantly, evidence of new infections among our nation's children, reached a nearly irreducible minimum. However, the termination of federal tuberculosis control project support in 1971 has already forced major reductions in preventive services for tuberculosis in many areas. The recent sharp decline in tuberculosis case rates is expected to be slowed if not reversed. Already there is evidence that tuberculosis infections are increasing in incidence in certain groups of the urban poor, especially non-white males.

A further lesson learned in the history of disease control in the United States, is the national scope of the threat posed by these diseases. By their very transmissible nature, communicable diseases know no geographic boundaries. Local control efforts are futile in the absence of a nationally coordinated effort. The natural tendency for communicable diseases to spread, particularly among major population conglomerations, has intensified greatly as our citizens have become more mobile in search of personal and occupational satisfaction. There can be no reasonable argument now against continuing federal responsibility in response to communicable disease control.

IV. Committee Views

The Committee regards this Bill with the highest priority.

1. There continue to be serious gaps in levels of immunization for children. In 1964, 87.6 percent of children between ages of one and four were immunized against polio. 1971 levels were 67.3 percent. Comparable immunization levels in 1971 include: measles, 67.4 percent; rubella, 51.2 percent, and diphtheria-pertussis tetanus, 78.7 percent. Comparable levels are even lower for the inner city and economically disadvantaged children.

Because of inadequate immunization, reported cases of such diseases continue. There were 75,000 cases of measles reported in 1971 in contrast to 47,000 for 1970. Rubella cases in 1971 were 44,000. There is concern that an outbreak of polio may occur unless vigorous efforts are made to reverse the decline in immunization. It is ill-advised to gamble with the health of children when there are effective vaccines available to prevent such diseases. This bill provides the impetus to target funds for eradication of such diseases.

2. The statistics on the incidence of venereal disease in the past year are shocking. Gonorrhea and syphilis are clearly approaching epidemic proportions. Gonorrhea, the most prevalent communicable disease in the Nation, accounted for 624,000 cases in 1971 with estimates of unreported cases to be 2,000,000! Of special concern is the data which suggests there may be 800,000 women who lack any symptoms of infection and yet are infected. They constitute a silent reservoir of infection with potentially serious complications. The Committee strongly endorses Title II of this legislation to begin to meet the overwhelming need for a national program against venereal disease as recommended by the President's National Commission on Venereal Disease.

3. The Committee is especially concerned with the faltering Federal support for tuberculosis control programs. For the first time in dcades there are no funds designated at the Federal level for the support of TB programs. In his testimony, Dr. Lee Reichman documented the effectiveness of the New York City TB project whose present Federal funding is scheduled to be eliminated. If funding is stopped, it will force the closure of 8 hospital-based clinics and transfer of 6,500 TB patients to other facilities. Elimination of Federal funding will seriously threaten similar programs throughout the country. The incidence of new cases of TB is now beginning to level off rather than decline and in urban areas may be increasing. In 1970, there were over 37,000 new active cases reported. Tuberculosis caused the death of 5,500 Americans, and remains the number one killer among communicable diseases. The Committee strongly endorses the testimony of the witnesses who urged continued strong Federal support for TB control programs.

The Committee was distressed to learn of the Administration's intention to terminate the funding for several on-going tuberculosis

programs. These programs are located in New York City; Newark, New Jersey; Erie County, New York; Puerto Rico; Washington, D.C.; Baltimore, Maryland; Pittsburgh, Pennsylvania; Alabama; Dade County, Florida; Fulton County, Georgia; Detroit, Michigan; El Paso, Texas; Houston, Texas; San Antonio, Texas; St. Louis, Missouri; San Francisco, California; Hawaii; and Alaska. The Committee directs the Department of HEW to continue the funding of these programs and to present to the Committee any proposals it may develop in respect to the future of these programs.

4. The 91st Congress enacted the Communicable Disease Control Amendments of 1970 to assist the States in sustaining effective efforts against the various communicable diseases. The passage of the Act marked an unmistakable affirmation that communicable diseases are (1) a national problem and (2) that the Federal Government has a continuing responsibility in their control. Despite this, the Administration has not requested appropriations under this authority. In fiscal year 1971, the Congress took the initiative and appropriated $2 million under section 317 to provide transitional funding to bring orderliness to the Administration's phaseout of the tuberculosis project grant program. Again in fiscal year 1972, the Congress took the initiative and appropriated $20 million under this authority. In fiscal year 1972, the Administration submitted a budget amendment requesting $10 million in formula grants for venereal disease control and vaccination assistance. The Congress recognized that $10 million was inadequate to meet the needs and that the formula grant approach was not the most efficient method of funding communicable disease programs. Therefore the $10 million was shifted to project grants under section 317 and an additional $10 million was added to the increase. Of this increase $16 million was to fund venereal disease control programs and $4 million for other community immunization programs. This action was taken in an effort to stem the dramatic increase in the venereal diseases and measles.

The Administration in their testimony before the Committee indicated special authority for communicable diseases, including venereal disease, was not needed.

The Committee, and the Congress, disagreed with the Administration in 1970 with regard to the necessity for a categorical program for communicable disease control and the Committee continues to disagree with the Administration in respect to this matter. This Committee in its report on the Health Services Improvement Act of 1970 stated:

> The Committee notes with concern the fact that a large proportion of the programs funded under section 314(e) continue to be too narrowly focused rather than focused upon the broader area of the organization and delivery of health services. In large part, of course, this is attributable to the fact that the states have not been as willing as the Congress had hoped, in funding these vitally important though narrower projects with funds made available under the bloc grant program, 314(d). The Congress is in the process of responding to this problem. The Senate has passed and the House will soon take up the Communicable Disease Control and Vaccination Assistance Amendments of 1969 which, if enacted, would authorize separate categorical project grant authority for these

> programs. At that time the Committee intends that HEW will, as rapidly as possible, insure that the projects funded under section 314(e) be primarily intended to grapple with the organization and delivery of comprehensive health services.

The House Committee on Interstate and Foreign Commerce in its report on the Communicable Disease Control Amendments of 1970 stated:

> As a practical matter, the categorical grant approach which was sought to be eliminated by Public Law 89–749 has not, in practice, worked exactly as planned. In each of its budget presentations each year since the enactment of section 314(e), the Department of Health, Education, and Welfare has earmarked specific amounts of the 314(e) fund request for specific programs for the coming year. In other words, the categorical grant approach has continued since the enactment of Public Law 89–749, except that instead of the Congress setting the categories, the categories have been set by the Department of HEW.
>
> One of the purposes of this bill is to restore some control to the Congress of the categories of health programs for which project grant funds are to be made available.
>
> Upon enactment of this legislation, the situation with respect to project grants will be restored to that prevailing in 1967 and 1968, at which time both section 314(e), providing overall authorizations for project grant funds, and section 317 of the Public Health Service Act, authorizing assistance for communicable disease prevention programs, were jointly operative.
>
> Upon enactment of this legislation, the administration will have available to it two separate authorizations for project grant programs—a general project grant authorization for health programs under section 314(e) and a communicable disease project grant authorization under this new legislation.

The Committee believes it is imperative that the federal government play a leadership role in providing a consistent and coordinated plan to prevent and control communicable diseases. And that it not inadequately play that role in a haphazard way at the expense of needed programs which support innovations in comprehensive health services. In his testimony for the Administration, Dr. DuVal, Assistant Secretary for Health and Scientific Affairs, DHEW, spoke of a need to reverse the present policy of risky and expensive crisis intervention in dealing with communicable diseases and to develop a more dependable health surveillance and maintenance approach.

In the Committee's view S. 3442 does provide for the best approach to combat and prevent communicable disease. In addition, the implementation of the provisions of the Committee's bill will enable the Administration to fully utilize existing authority under Section 314 (e) of the Public Health Service Act for the principal purpose for which it was enacted—support of comprehensive health service programs. In this respect and for that purpose the Committee's bill does grant the Administration's request that the authorization ceiling for

section 314(e) be increased from $157,000,000 to $179,000,000 for fiscal year 1973.

5. Based upon the reluctance of the Administration to utilize the existing authority under section 317 of the Public Health Service Act in the face of the legislative history made by the Congress in 1970, the Committee now feels the only effective method to insure the use of a targeted communicable disease program authority is to legislatively prohibit the utilization of the authority contained within section 314(e) or any other provision of the Public Health Service Act for programs of the type authorized by the Committee's bill. The Committee does not, however, intend to preclude the funding of comprehensive health service programs under section 314(e), which include, as a subpart thereof, communicable disease control or immunization programs, nor is it intended to preclude such components in other activities under the PHS Act which are primarily concerned with the provision of services for other purposes, such as those providing care for PHS beneficiaries and Federal employees, for supporting migrant health services, or family planning service projects.

Perhaps, the best example of the need for this provision in the Committee's bill can be found in the recent report on communicable disease activities of the Secretary of HEW required by Public Law 91-464. That report states:

"Section 317 of the Public Health Service Act, as amended by Public Law 91-464 (84 Stat. 988), authorized the appropriation of $75 million for fiscal year 1971 and $90 million for fiscal year 1972, to enable the Secretary of Health, Education, and Welfare to make grants to States and, with the approval of the State health authority, to political subdivisions or instrumentalities of the States for communicable disease control programs.

"TUBERCULOSIS

"In fiscal year 1971, Congress appropriated $2 million to implement this legislation. The Department of Health, Education, and Welfare decided to use these funds to assist States in completing the phaseout of the tuberculosis control project grant program which had been supported under section 314(e) of the Partnership for Health legislation. In 1970 some $18 million was transferred from 314(e) project grants to 314(d) formula grants for the control of tuberculosis at the State level. This shift in funding mechanism was consistent with the basic concept of the Partnership for Health legislation. The basic intent of that legislation was to establish a Federal-State relationship in which States receive block-type formula grants to establish or maintain adequate public health services. Project grant funds were intended to support, for a short period of time, new and innovative programs for health services. Since the methods for control of tuberculosis were well known and generally used, it was appropriate that these funds be transferred from special project-type funding 314(e) to block-type formula grant funding 314(d). Because this change represented only a change in funding mechanism and not in the availability of funds for tuberculosis control activities, the Department did not request funds for tuberculosis control under the Communicable Disease Control Amendments. Knowing that some States would

experience financial problems because of the shift, a program of transitional funding was developed in order to maintain tuberculosis control activities. In fiscal years 1970 and 1971, $3.3 million was made available from section 314(e) funds to provide transitional funding in areas which: (1) Still had significant tuberculosis problems and (2) received less financial support under the formula grant distribution than they previously had been awarded under tuberculosis control project grants. The $2 million appropriated under the Communicable Disease Control Amendments of 1970 has been used to continue the phaseout of project support for tuberculosis by forward funding tuberculosis control activities in fiscal year 1972. The funds are being used primarily to support outpatient clinics which had been established with previous grant funds. The major portion of the expenditures is for personnel and supplies needed to complete the treatment of individuals with active tuberculosis and to provide preventive therapy for suspects and contacts of infectious tuberculosis cases.

"VENEREAL DISEASES

"Venereal diseases remain a continuing problem throughout the United States today. After a 4-year decline in incidence during the mid-1960's when the Nationwide syphilis eradication program was at its maximum, the incidence of syphilis has once again been on the increase. Gonorrhea has been increasing since 1957, but in the last few years, the annual increase has been dramatic—to the point where more than 600,000 cases were reported in 1971. Recognizing the need to act to curb the spread of these and other communicable diseases, the Department submitted a budget amendment requesting a $10 million increase in 314(d) formula grant funds over the original fiscal year 1971 budget request to provide additional assistance to the States. While the States would decide which health services these funds would be used for, the Department expected to encourage the States to use these funds for venereal disease and community immunization programs. The Congress did not act on this request but appropriated $20 million—$16 million earmarked for venereal disease under the authority of the Communicable Disease Control Amendments of 1970. These funds are in addition to the $6.3 million that has been identified for the control of syphilis under section 314(e). These grant funds, a total of $22.3 million, will enable States and communities to initiate gonorrhea control programs and to once again start down the road toward the eradication of syphilis.

"IMMUNIZATION PROGRAMS

"In recent years, Nationwide immunization levels against some of the major childhood diseases have declined, particularly among the urban and rural poor in the one through four age group. The results of this deterioration of protection became evident during 1970 in outbreaks of diphtheria, continued high levels of susceptibility to poliomyelitis in inner cities, and a continued upswing in the number of cases of measles. To correct this trend the Department in 1971 authorized the use of $6 million in funds that had been appropriated for rubella under section 314(e) for the purchase of measles, poliomyelitis,

and the newly licensed rubella-measles vaccine. The $6 million was available because of substantially larger decreases in the cost of rubella vaccine than had originally been estimated. The combined measles-rubella vaccine which permits simultaneous immunization against both measles and rubella will provide a stimulus to the programs. To continue these programs, $4 million for the support of immunization activities was appropriated in 1972 under the authority in section 317. These additional funds together with the $13 million that has been identified under section 314(e) for the national rubella immunization program will make it possible for States and communities to undertake a coordinated national immunization program against measles, poliomyelitis, and diphtheria, as well as rubella."

6. The Committee was so deeply concerned by the alarming rate of increase in venereal disease that they amended the bill to include as a separate title the "Venereal Disease Control and Prevention Act of 1972". The Committee envisioned the program authorized by this title of the bill as essential to control venereal diseases which have complex roots in human behavior, are increasing rapidly in epidemic proportions—witnesses estimated that there were 2,500,000 cases of gonorrhea and 100,000 cases of infectious syphilis in the United States during 1971—and because failure of past control measures to do the job demands the development of new, innovative, additional techniques and programs. The Committee believes there have been only minimal amounts of research in the basic aspects of syphilis and gonorrhea in the United States and an expanded and coordinated research program should be initiated. Work on important areas of need should be instigated to increase our basic knowledge of the microbiology and immunology of the gonococcus and the treponema pallidum which causes syphillis; to develop better diagnostic methods and screening tests for gonorrhea and research into the development of syphilis and gonorrhea vaccines need greater emphasis. The Committee further believes that much greater emphasis must be placed upon professional and public education concerning venereal diseases than has heretofore been carried on. Ways must be devised to bring instruction concerning venereal disease into the medical schools in this country; to increase the understanding among private physicians of the venereal disease problem; and to initiate support for programs of public education, including education concerning venereal diseases as part of the curriculum of schools, no later than the seventh grade.

The Committee retained the formula for the grants to the States provision, but increased the minimum allotment and authorization. The Committee was impressed with the need to assure adequate and equitable funding for venereal disease programs to all the States. In order to compensate for the advantage accruing to the more populous states under the VD formula grant provision, the Committee recommends that the VD project grant provision be administered in such a way as to give an appropriate priority to the less populous states while at the same time ensuring equitable funding for all states. The recommendation is based upon the understanding that there will be adequate appropriations for the funding of all the authorizations provided by this title.

The Committee was impressed with the need to overcome the concomitant problem of venereal disease sufferers failing to seek treatment

due to their concern that their identity would be divulged and physician failure to report incidence of venereal disease cases because of local public health laws which require them to breach the "physician-patient" relationship of confidentiality by providing the patient's name. The Committee amended the bill to ensure that patient examination, care and treatment shall be held confidential and identity sacrosanct except with the individual's consent or as may be necessary to provide service to the individual, in the utilization of any funds made available under this bill.

Any provision of information to State public health authorities from programs so funded would thus have to be made without identifying the patient. The Committee was also concerned that in writing up clinical studies, researchers should do all possible to ensure that the particulars of the case do not reveal the identity of the patient.

7. In response to the Administration's request for increased appropriations authorization for project grants and contracts for family planning services, the Committee added an amendment increasing the Public Health Service title X authority for this purpose by $37,300,000 from $90,000,000 to $127,300,000 for fiscal year 1973.

The Committee determined that the administration request for an increase of $21.5 million to a total authorization of $111.5 million was insufficient to keep the Federal programs on target to meet the announced Federal goal of providing family planning services by 1975 to the approximately 6.5 million women wanting them but not able to afford them. In order to reach this goal, established in the Department of Health, Education, and Welfare's Five-Year Plan for Family planning Services and Population Research (submitted on October 12, 1971), the Five-Year Plan estimated that the number of women reached must increase each year by approximately 800,000. Specifically, the administration's requested increase would have authorized sufficient funds to provide services to only an additional 500,000 women rather than the 763,000 projected in the Five-Year Plan.

The $127,300,000 authorization which the Committee has adopted instead will enable the administration to reach this goal. The Department of Health, Education, and Welfare estimates the Federal share of providing family planning services to each individual at approximately $60. The additional $15.8 million added to the administration's request by the Committee bill will enable family planning service programs to provide services to an additional 263,000 women.

The Special Subcommittee on Human Resources held a full day of hearings (April 17, 1972) on the suggested increase and received testimony from the Administration, from representatives of organizations coordinating family planning service programs on a nationwide basis as well as directors of programs in specific communities in Illinois and Ohio. These hearings demonstrated that the $21.5 million increase for PHS Act title X authority project grants was offset almost entirely by an $18 million reduction below Fiscal Year 1972 spending for Social Security Act title V (Maternal and Child Heatlh Project) grants (minus $9 million) and EOE Family planning projects (minus $9 million). Information provided at those hearings presented convincing documentation of the need for and H.E.W.'s ability to utilize effectively the amount included in the Committee bill.

V. Tabulation of Votes Cast in Committee

Pursuant to section 133(b) of the Legislative Reorganization Act of 1946, as amended, the following is a tabulation of votes in Committee:

Motion to report the bill to the Senate carried unanimously.

VI. Cost Estimates Pursuant to Sec. 252 of the Legislative Reorganization Act of 1970

Title I	$534,300,000
Title II	225,000,000
Total	759,300,000

VII. Section-by-Section Analysis

Section 101(a) replaces Section 317(a) of the Public Health Service Act with a new section 317(a). It re-authorizes and extends through fiscal year 1977 grants for communicable disease control. It authorizes the Secretary to make grants for such purposes to states and the agencies and political subdivisions of the states. It directs the Secretary to consult with state health authorities in awarding such grants to agencies and political subdivisions of the states. When awarding such grants, the Secretary shall give consideration to the relative extent of the problems relating to the diseases outlined in subsection (b)(1) of this act and to the design of public health programs. Grants will be used to meet costs of control programs and attendant laboratory services. For such grants, there are authorized to be appropriated $90 million for the fiscal year ending June 30, 1973; $90 million for year ending June 30, 1974; $90 million for the fiscal year ending June 30, 1975; $90 million for the fiscal year ending June 30, 1976; and $90 million for the fiscal year ending June 30, 1977.

Section 101(b)(1) is a technical amendment to section 317(a) of the Public Health Service Act.

Section 101(b)(2) removes the restriction that requires the Secretary to determine which communicable disease control programs are necessary on the recommendation of the National Advisory Health Council.

Section 101(c) amends subsection (f) by enlarging the scope of the Secretary's annual report on activities in communicable disease programs.

Section 101(d) adds two new subsections to section 317. New subsection (h) authorizes the Secretary to enter into contracts with private and nonprofit agencies and organizations for public education on the consequences of communicable disease infections and availability of programs for immunization against such infections. For such grants there are authorized to be appropriated: $5 million for the

fiscal year ending June 30, 1973; $5 million for the fiscal year ending June 30, 1974; $5 million for the fiscal year ending June 30, 1975; $5 million for the fiscal year ending June 30, 1976; and $5 million for the fiscal ending June 30, 1977.

New subsection (i) limits the funding for all communicable diseases programs to the authority of Section 317 except for Section 318 of the Public Health Service Act.

Section 102 amends Section 314(e) of the Public Health Service Act to increase the authorization level from $157,000,000 to $179,000,000 for fiscal year 1973.

Section 103 amends Section 1001(c) of the Public Health Service Act to increase the authorization level from $90,000,000 to $127,300,000 for fiscal year 1973.

Section 201 states that Title II of this Act may be cited as the National Venereal Disease Prevention and Control title.

Section 202 describes seven major findings to justify the need for legislation and declares that it is the purpose of this Title to establish a national program for the prevention and control of venereal disease and amends Title Three of the Public Health Service Act to create new Section 318: Section 318(a) authorizes the Secretary to conduct and render assistance for research and training and public health programs in the prevention and control of venereal disease.

Section 318(b) authorizes the Secretary to make projects grants for research, demonstration or training for the prevention and control of venereal disease. For such grants there are authorized to be appropriated $15 million for the fiscal year ending June 30, 1973 and for each of the next two succeeding fiscal years.

Section 318(c)(1) authorizes the Secretary to make grants to states for establishing and maintaining programs for diagnosis and treatment of venereal disease. For such grants there is authorized to be appropriated $30 million for the fiscal year ending June 30, 1973 and for each of the next two succeeding fiscal years.

Section 318(c)(2) denominates the criteria which the states must include in their plans to obtain grants under this section.

Section 318(c)(3) authorizes allotments to the several states based on the incidence of venereal disease in and population of the respective states. It provides that no state allotment shall be less than $75,000 for any fiscal year.

Section 318(c)(4) sets the standards and formulas on which allotments to states and territories shall be made.

Section 318(c)(5) requires that at least 70% of a state allotment under this subsection must be available for services in the communities of the state.

Section 318(d) authorizes the Secretary to make project grants to the states and in consultation with the state health authority to political subdivisions of states and enumerates the factors which define a venereal disease prevention and control program.

Section 318(e) grants the Secretary discretionary authority for grant purposes under subsections (b) and (d) under such terms and conditions as he finds necessary to carry out the purposes of these subsections.

Section 318 (f) states that this section shall not be construed to limit use or availability of funding for similar purposes under Section 317 of this Act.

Section 318 (g) authorizes to be appropriated under subsection (d) $30 million for the fiscal year ending June 30, 1973, and for each of the next two succeding fiscal years.

Section 318 (h) grants the Secretary authority to require of the recipients of assistance under this section such record keeping as deemed necessary.

Section 318 (i) grants the Secretary and Comptroller General or any of their authorized representatives to audit and examine records and documents of the recipients pertinent to the assistance received.

Section 318 (j) grants the Secretary discretionary authority to reduce the amount of individual grants under this Section for certain administrative reasons.

Section 318 (k) provides for confidentiality of all information obtained from those who receive treatment and care under programs funded under this Section. Data for statistical purposes may be used to long as individuals are not identified.

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VIII. Changes in Existing Law

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

*   *   *   *   *

Part B—Federal-State Cooperation

*   *   *   *   *

IN GENERAL

GRANTS TO STATES FOR COMPREHENSIVE STATE HEALTH PLANNING

Sec. 314. (a) (1) Authorization.—In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Secretary is authorized during the period beginning July 1, 1966, and ending June 30, 1973, to make grants to States which have submitted, and had approved by the Secretary, State plans for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $2,500,000 for the fiscal year ending June 30, 1967, $7,000,000 for the fiscal year ending June 2, 1968, $10,000,000 for the fiscal year ending June 30, 1969, $15,000,000 for the fiscal year ending June 30, 1970, $15,000,000 for the fiscal year ending June 30, 1971, $17,000,000 for the fiscal year ending June 30, 1972, and $20,000,000 for the fiscal year ending June 30, 1973.

(2) State plans for comprehensive state health flanning.—In order to be approved for purposes of this subsection, a State plan for comprehensive State health planning must—

(A) designate, or provide for the establishment of, a single State agency, which may be an interdepartmental agency, as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;

(B) provide for the establishment of a State health planning council, which shall include representatives of Federal, State, and local agencies (including as an ex officio member, if there is lo-

cated in such State one or more hospitals or other health care facilities of the Veterans' Administration, the individual whom the Administrator of Veterans' Affairs shall have designated to serve on such council as the representative of the hospitals or other health care facilities of such Administration which are located in such State) and nongovernmental organizations and groups concerned with health (including representation of the regional medical program or programs included in whole or in part within the State), and of consumers of health services, to advise such State agency in carrying out its functions under the plan, and a majority of the membership of such council shall consist of representatives of consumers of health services;

(C) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Secretary, are designed to provide for comprehensive State planning for health services (both public and private and including home health care), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State and including environmental considerations as they relate to public health;

(D) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation;

(E) contain or be supported by assurances satisfactory to the Secretary that the funds paid under this subsection will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(G) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

(H) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Secretary appropriate modifications thereof;

(I) effective July 1, 1968, (i) provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria established by the Secretary after consultation with

the State which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and (ii) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (i)) of each health care facility in the State and recommended appropriate modification thereof;

(J) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subsection; and

(K) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this subsection.

(3)(A) State allotments.—From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year pursuant to paragraph (1). Any such allotment to a State for a fiscal year shall remain available for obligation by the State, in accordance with the provisions of this subsection and the State's plan approved thereunder, until the close of the succeeding fiscal year.

(B) The amount of any allotment to a State under subparagraph (A) for any fiscal year which the Secretary determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallotment by the Secretary from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under subparagraph (A) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallotted among the States who proportionate amounts were not so reduced. Any amount so reallotted to a State from funds appropriated pursuant to this subsection for a fiscal year shall be deemed part of its allotment under subparagraph (A) for such fiscal year.

(4) Payments to states.—From each State's allotment for a fiscal year under this subsection, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this subsection. Such payments shall be made on the basis of estimates by the Secretary of the sums the State will need in order to perform the planning under its approved State plan under this subsection, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The "Federal share" for any State for purposes of this subsection shall be all, or such part as the Secretary may determine, of the cost of such planning, except that in the case of the allotments for the fiscal year ending June 30, 1970, it shall not exceed 75 per centum, of such cost.

PROJECT GRANTS FOR AREAWIDE HEALTH PLANNING

(b)(1)(A) The Secretary is authorized, during the period beginning July 1, 1966, and ending June 30, 1973, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization (but with appropriate representation of the interests of local government where the recipient of the grant is not a local government or combination thereof or an agency of such government or combination) to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services; and including the provision of such services through home health care; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. No grant may be made under this subsection after June 30, 1970, to any agency or organization to develop or revise health plans for an area unless the Secretary determines that such agency or organization provides means for appropriate representation of the interests of the hospitals, other health care facilities, and practicing physicians serving such area, and the general public. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1967, $7,500,000 for the fiscal year ending June 30, 1968, $10,000,000 for the fiscal year ending June 30, 1969, $15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $30,000,000 for the fiscal year ending June 30, 1972, $40,000,000 for the fiscal year ending June 30, 1973.

(B) Project grants may be made by the Secretary under subparagraph (A) to the State agency administering or supervising the administration of the State plan approved under subsection (a) with respect to a particular region or area, but only if (i) no application for such a grant with respect to such region or area has been filed by any other agency or organization qualified to receive such a grant, and (ii) such State agency certifies, and the Secretary finds, that ample opportunity has been afforded to qualified agencies and organizations to file application for such a grant with respect to such region or area and that it is improbable that, in the foreseeable future, any agency or organization which is qualified for such a grant will file application therefor.

(2)(A) In order to be approved under this subsection, an application for a grant under this subsection must contain or be supported by reasonable assurances that there has been or will be established, in or for the area with respect to which such grant is sought, an areawide health planning council. The membership of such council shall include representatives of public, voluntary, and nonprofit private agencies, institutions, and organizations concerned with health (including representatives of the interests of local government of the regional medical program for such area, and of consumers of health services). A majority of the members of such council shall consist of representatives of consumers of health services.

(B) In addition, an application for a grant under this subsection must contain or be supported by reasonable assurances that the areawide health planning agency has made provision for asisting health care facilities in its area to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan which will meet the needs of the State and the area for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner.

PROJECT GRANTS FOR TRAINING, STUDIES, AND DEMONSTRATIONS

(c) The Secretary is also authorized, during the period beginning July 1, 1966, and ending June 30, 1973, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $1,500,000 for the fiscal year ending June 30, 1967, $2,500,000 for the fiscal year ending June 30, 1968, $5,000,000 for the fiscal year ending June 30, 1969, $7,500,000 for the fiscal year ending June 30, 1970, $8,000,000 for the fiscal year ending June 30, 1971, $10,000,000 for the fiscal year ending June 30, 1972, and $12,000,000 for the fiscal year ending June 30, 1973.

GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

(d) (1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $70,000,000 for the fiscal year ending June 30, 1968, $90,000,000 for the fiscal year ending June 30, 1969, $100,000,000 for the fiscal year ending June 30, 1970, $130,000,000 for the fiscal year ending June 30, 1971, $145,000,000 for the fiscal year ending June 30, 1972, and $165,000,000 for the fiscal year ending June 30, 1973, to enable the Secretary to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for provision of public health services.

(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES.—In order to be approved under this subsection, a State plan for provision of public health services must—

(A) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

(B) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

(C) contain or be supported by assurances satisfactory to the Secretary that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people; (ii) such

funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Secretary determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; (iii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds; and (iv) the plan is compatible with the total health program of the State;

(D) provide for the furnishing of public health services under the State plan in accordance with such plans as have been developed pursuant to subsection (a);

(E) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(G) provide that the State health authority or, with respect to mental health services, the State mental health authority, will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection and submit to the Secretary appropriate modifications thereof;

(H) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this subsection;

(J) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this subsection;

(K) provide for services for the prevention and treatment of drug abuse and drug dependence, commensurate with the extent of the problem, and

(L) Provide for services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of the problem.

(3) State allotments.—From the sums appropriated to carry out the provisions of this subsection the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States, except that no State's allotment shall be less for any year than

the total amounts allotted to such State under formula grants for cancer control, plus other allotments under this section, for the fiscal year ending June 30, 1967.

(4) (A) PAYMENTS TO STATES.—From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Secretary of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this subsection.

(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be regarded as expenditures by such State or a political subdivision thereof.

(5) FEDERAL SHARE.—The "Federal share" for any State for purposes of this subsection shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than 33⅓ per centum or more than 66⅔ per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Virgin Islands shall be 66⅔ per centum.

(6) DETERMINATION OF FEDERAL SHARES.—The Federal shares shall be determined by the Secretary between July 1 and September 1 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

(7) ALLOCATION OF FUNDS WITHIN THE STATES.—At least 15 per centum of a State's allotment under this subsection shall be available only to the State mental health authority for the provision under the State plan of mental health services. Effective with respect to allotments under this subsection for fiscal years ending after June 30, 1968, at least 70 per centum of such amount reserved for mental health services and at least 70 per centum of the remainder of a State's allotment under this subsection shall be available only for the provision under the State plan of services in communities of the State.

PROJECT GRANTS FOR HEALTH SERVICES DEVELOPMENT

(e) There are authorized to be appropriated $90,000,000 for the fiscal year ending June 30, 1968, $95,000,000 for the fiscal year ending June 30, 1969, $80,000,000 for the fiscal year ending June 30, 1970, $109,500,000 for the fiscal year ending June 30, 1971, $135,000,000 for the fiscal year ending June 30, 1972, and [$157,000,000] *$179,000,000* for the fiscal year ending June 30, 1973, for grants to any public or

nonprofit private agency, institution, or organization to cover part of the cost (including equity requirements and amortization of loans on facilities acquired from the Office of Economic Opportunity or construction in connection with any program or project transferred from the Office of Economic Opportunity) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Any grant made under this subsection may be made only if the application for such grant has been referred for review and comment to the appropriate areawide health planning agency or agencies (or, if there is no such agency in the area, then to such other public or nonprofit private agency or organization (if any) which performs similar functions) and only if the services assisted under such grant will be provided in accordance with such plans as have been developed pursuant to subsection (a).

* * * * * * *

COMMUNICABLE DISEASE CONTROL AND VACCINATION ASSISTANCE

SEC. 317. (a) There are [hereby] authorized to be appropriated [$75,000,000 for the fiscal year ending June 30, 1971, and] $90,000,000 for the fiscal year ending June 30, 1972*; $90,000,000 for fiscal year ending June 30, 1973; and each of the next four succeeding fiscal years* to enable the Secretary to make grants to States [and, with the approval of] *and in consultation with* the State health authority, to *agencies and* political subdivisions [or instrumentalities] of the States under this subsection. In the [award] *awarding* of such [grants] *grants*, the Secretary shall give consideration to the relative extent of the problems relating to one or more of the diseases referred to in subsection (b)(1) and to the [levels of] *design of the public health program to assure effective* performance in preventing and controlling such diseases. Such grants may be used for meeting the cost of communicable disease control [programs,] *programs and their attendant laboratory services*, including the cost of studies to determine the communicable disease control needs of communities and the [means of best] *best means of* meeting such needs.

(b) For the purposes of this [subsection—] *section—*

(1) a "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 which are determined by the Secretary [on the recommendation of the National Advisory Health Council] to be of national significance, and

(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.

(c) Payments 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, in such install-

ments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of this section.

(d) 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, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when the furnishing of such supplies or equipment, or of the detail of such officer or employee (as the case may be) 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, equipment, or personal services on which the reduction of such grant is based, but such amount shall be deemed a part of the grant to such recipient and shall, for the purposes of subsection (c), be deemed to have been paid to such agency.

(e) 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.

(f) The Secretary shall submit an annual report to the President for submission to the Congress on the effectiveness of activities [assisted under this section] in preventing and controlling communicable diseases.

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

(h)(1) The Secretary is authorized to make grants to, and enter into contracts with, public and private nonprofit agencies, organizations, and institutions for the purpose of making the citizens of the United States aware of the consequences of the diseases described in subsection (b)(1) and the programs available which will avert such consequences.

(2) For the purpose of carrying out this subsection, there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1973, and each of the next four succeeding fiscal years.

(i) Except for section 318 of this Act, notwithstanding any other provision of law unless enacted after the enactment of this Act expressly in limitation of this section, no funds appropriated pursuant to the authorization of any section of the Public Health Service Act other than this section shall be available for communicable disease control or vaccination assistance programs of the type authorized under this section.

PROJECTS AND PROGRAMS FOR THE PREVENTION AND CONTROL OF VENEREAL DISEASE

SEC. 318. (a) The Secretary is authorized 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.

(b) (1) The Secretary is authorized to make grants to States, political subdivisions, universities, hospitals, and other public or nonprofit private institutions, agencies, institutions, or organizations, for projects for the conduct of research, demonstrations, or training for the prevention or control of venereal disease.

(2) For the purpose of carrying out this subsection there is authorized to be appropriated the sum of $15,000,000 for the fiscal year ending June 30, 1973, and for each of the next two succeeding fiscal years.

(c) (1) There is authorized to be appropriated the sum of $30,000,000 for the fiscal year ending June 30, 1973, and for each of the next two succeeding fiscal years, to enable the Secretary to make grants to State health authorities to assist the States in establishing and maintaining adequate public health programs for the diagnosis and treatment of venereal disease. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for the provision of public health services for the diagnosis and treatment of venereal disease.

(2) In order to be approved under this subsection, a State plan for the provision of public health services for the diagnosis and treatment of venereal disease must—

(A) provide for the administration or supervision of administration by the State health authority;

(B) set forth the policies and procedures to be followed in the expenditure of the funds paid to the State under this subsection;

(C) provide that the public health services furnished under the plan will include the provision of statewide laboratory services which include Darkfield microscopes for the diagnosis of both gonorrhea and syphilis, and will otherwise be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

(D) contain or be supported by assurances satisfactory to the Secretary that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services for the diagnosis and treatment of venereal disease in the various political subdivisions in order to improve the health of the people; (ii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant any non-Federal funds which would otherwise be available for such purpose; and (iii) the plan is compatible with the total health program of the State;

(E) provide that the State health authority will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection, and submit to the Secretary appropriate modifications thereof;

(F) provide that the State health authority will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

(G) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this subsection; and

(H) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this subsection.

(3) From the sums appropriated to carry out the provisions of this subsection, the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the incidence of venereal disease in, and the population of, the respective States; except that no State's allotment shall be less than $75,000 for any fiscal year.

(4)(A) From each State's allotment under this subsection for a fiscal year, the State shall be paid a Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Secretary or by way of reimbursement, with necessary adjustments on account of previous underpayments or overpayments.

(B) The Federal share for any State shall be such per centum (not in excess of 90 per centum) of the expenditures of such State (referred to in subparagraph (A)) as shall be established by such State.

(C) "State" means each of the several States of the United States, the District of Columbia, the Virgin Islands, Guam, American Samoa, Trust Territory of the Pacific Islands, and the Commonwealth of Puerto Rico.

(D) Any amount so allotted to a State during any such fiscal year (other than the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, and the Commonwealth of Puerto Rico) and remaining unobligated at the end of such year shall remain available to such State, for the purposes for which made, for the next fiscal year (and for such year only) and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year; except that any such amount remaining unobligated at the end of the sixth month following the end of such year for which it was allotted which the Secretary determines will remain unobligated by the close of such next fiscal year may be reallotted by the Secretary, to be available for the purposes for which made until the close of such next fiscal year, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this subsection, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the States for the same period. Any amount allotted under this subsection of this section to the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, or the Commonwealth of Puerto Rico for a fiscal year and remaining unobligated at the end of such year shall remain available to it for the purposes for which made, for the next two fiscal years (and for such years only), and any such amount shall be in addition to the amounts allotted to it for such purpose for each of such next two fiscal years; except that any such amount, remaining unobligtaed at the end of the first of such next two years, which the Secretary determines will remain unobli-

gated at the close of the second of such next two years, may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to any other of such named States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this part, and any amount so reallotted to any such State shall be in addition to any other amounts allotted and available to it for the same period.

(5) Effective with respect to allotments under this subsection at least 70 per centum of a State's allotment under this subsection shall be available only for the provision under the State plan of services in communities of the State.

(d) (1) The Secretary is authorized to make project grants to States and, in consultation with the State health authority, to political subdivisions of States, for the conduct of venereal disease prevention and control programs.

(2) For purposes of this subsection, the term "venereal disease prevention and control program" means a program which includes—

(A) disease surveillance activities, including the reporting, screening, and followup of diagnostic tests and diagnosed cases of venereal disease;

(B) casefinding and case followup activities, including contact tracing of infectious cases;

(C) interstate epidemiologic referral and followup activities;

(D) professional and public venereal disease education activities; and

(E) such special studies or demonstrations to evaluate or test venereal disease control as may be prescribed by the Secretary.

(e) Grants made under subsection (b) or (d) of this section shall be made on such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary.

(f) Nothing in this section shall be construed to limit or otherwise restrict the use or availability of funds which are granted to a State or to a political subdivision of a State under other provisions of section 317 of this Act which are available for the conduct of venereal disease programs from being used in connection with programs assisted through grants under this section.

(g) For the purpose of carrying out this subsection, there is authorized to be appropriated the sum of $30,000,000 for the fiscal year ending June 30, 1973, and for each of the next two succeeding fiscal years.

(h) Each recipient of assistance under this section shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such assistance, the total cost of the project or undertaking in connection with which such assistance is given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

(i) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers,

and records of the recipients that are pertinent to the assistance received under this section.

(j) 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, or equipment furnished to such recipient and by the amount of pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when the furnishing of such supplies or equipment, or the detail of such officer or employee (as the case may be), 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, equipment, or personal services on which the reduction of such grant is based, but such amount shall be deemed a part of the grant to such recipient and shall, for the purposes of this section, be deemed to have been paid to such agency.

(k) Any grant awarded pursuant to this section shall be subject to the condition that all information obtained by the personnel of the project from participants in the project related to their examination, care, and treatment, shall be held confidential, and shall not be divulged without the individual's consent except as may be necessary to provide service to the individual. Information may be disclosed in summary, statistical, or other form or for clinical and research purposes in such a way as not to identify particular individuals.

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TITLE X—POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES

SEC. 1001. (a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects.

(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance.

(c) For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; and [$90,000,000] *$127,300,000* for the fiscal year ending June 30, 1973.

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