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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1976

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE

DANIEL J. FLOOD, Pennsylvania, *Chairman*

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PART 2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE:

HEALTH ACTIVITIES

(Excluding National Institutes of Health)

Printed for the use of the Committee on Appropriations

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR FISCAL YEAR 1976

MONDAY, APRIL 7, 1975.

ASSISTANT SECRETARY FOR HEALTH

WITNESSES

DR. THEODORE COOPER, ACTING ASSISTANT SECRETARY FOR HEALTH
DR. HENRY E. SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH
DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL
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DR. HAROLD MARGULIES, DEPUTY ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION

INTRODUCTION OF WITNESSES

Mr. FLOOD. We now have the Department of Health, Education, and Welfare and the health programs of that agency. The presentation will be made for us by Dr. Theodore Cooper, Acting Assistant Secretary for Health.

I see that you have quite an array of talent with you. Do you mind if we meet them?

Dr. COOPER. I would be delighted if you would meet them, Mr. Flood. Starting from my left to right, Dr. Harold Margulies, Deputy Administrator of the Health Resources Administration; Dr. Endicott could not be here today. Dr. Ronald Lamont-Havers, Acting Director of the National Institutes of Health; Dr. Robert van Hoek, Acting Administrator of the Health Services Administration; Mr. Peter J. Bersano, the Director, Division of Financial Management, Public Health Service.

To my right, Mr. James Isbister, the Acting Administrator of the Alcohol, Drug Abuse, and Mental Health Administration; Dr. David J. Sencer, Director of the Center for Disease Control.

At the far end, Mr. Charles Miller, Deputy Assistant Secretary, Comptroller.

Mr. FLOOD. I see that you have a biographical sketch, which we will insert in the record at this point.

[Dr. Cooper's biographical sketch follows:]

BIOGRAPHICAL SKETCH

Name: Theodore Cooper, M.D.

Position: Acting Assistant Secretary for Health.

Birthplace and date: Trenton, N.J., December 28, 1928.

Education: June 1946—Graduated from high school; June 1949—B.S., Georgetown University; June 1954—M.D., St. Louis University; 1956—Ph. D., St. Louis University.

Experience: 1974 to present: Deputy Assistant Secretary for Health, Department of Health, Education, and Welfare.

1968 to 1974: Director, National Heart and Lung Institute.

1967 to 1968: Associate Director for Artificial Heart-Myocardial Infarction Program-National Heart Institute.

1966 to 1968: Professor and chairman, Department of Pharmacology and Professor of Surgery, University of New Mexico School of Medicine.

1964 to 1966: Professor of surgery, St. Louis University.

1962 to 1964: Associate professor of surgery, St. Louis University.

1961 to 1965: Director, Center for Cardiovascular Research, St. Louis University.

1960 to 1962: Assistant professor of surgery, director, section of surgical physiology, St. Louis University.

1959 to 1960: Surgeon, U.S. Public Health Service, National Heart Institute.

1958 to 1959: Assistant resident in surgery, St. Mary's Group of Hospitals, St. Louis University.

1956 to 1958: S.A. Surgeon, U.S. Public Health Service, National Heart Institute.

1954 to 1955: Intern, St. Mary's Group of Hospitals, St. Louis University.

Professional organizations: American Thoracic Society, American Society for Clinical Investigation, American Physiological Society, Society for Experimental Biology and Medicine, American Society for Pharmacology and Experimental Therapeutics, International Cardiovascular Society, American College of Chest Physicians, American Society for Artificial Organs, American Federation for Clinical Research, American Association of University Professors, American Association for Advancement of Science, American College of Cardiology, Japanese Pharmacological Society, American Heart Association, Association of Military Surgeons, Commissioned Officers Association-USPHS, Sigma Xi, Alpha Omega Alpha, Phil Delta Epsilon.

Honors and awards: Bordon Award, St. Louis University, 1954. Who's Who in American Colleges and Universities, 1956. Research Career Development Award, USPHS, 1962–1966. DHEW Superior Service Honor Award, 1972. St. Louis University Alumni Merit Award, 1972. James E. Perkins Lecture-NTRDA, Los Angeles, 1971. Southern Medical Association Lecture, Baylor College of Medicine, Houston, 1971. G. Lyman Duff Memorial Lecture-AHA, Anaheim, 1971. George E. Brown Memorial Lecture-AHA, Anaheim, 1971. Arthur M. Master Lecture, Mount Sinai School of Medicine, N.Y., 1972. John J. Hammond Lecture, St. John's Mercy Medical Center, St. Louis, 1972. Sixteenth Honorary Lecture Award, Albany Medical College, Albany, 1972.

Mr. FLOOD. As you know, the practice, if and when any of your colleagues feel called upon to volunteer, they should do so. If you wish to call on any of them, not only the ones at the table but anyone else, do that. You will then insert a short biographical sketch of that witness, if and when.

Dr. COOPER. I will, sir. They are most eager to volunteer.

OPENING STATEMENT

Mr. FLOOD. I am sure of that.

I see that you have a prepared statement. How do you wish to handle that?

Dr. COOPER. I would propose, sir, if it is all right with you, to read the statement and then answer questions during or after the statement.

Mr. FLOOD. Suppose you do that.

STATEMENT BY THE ACTING ASSISTANT SECRETARY FOR HEALTH

Dr. COOPER. Mr. Chairman and members of the committee, I would like to review for you the Public Health Service's budget estimates submitted to Congress for 1976. Each health agency administrator or director will be presenting to you later the budget estimates for his programs in greater detail.

Before I begin discussing the budget, I would like to provide you some noteworthy data on the health of the American people.

HEALTH STATUS

In the recent past, there has been a great deal of attention given the leveling off of mortality trends in the United States. After many years of a steady decline in mortality rates, the rates began to level off between the mid-1950's until the late 1960's. Since 1968, we have again been experiencing a decline in mortality rates of almost 1 percent per year. The decline in mortality is particularly marked among selected diseases and within specific age and sex groups. For example, the death rates for coronary heart disease, one of the leading causes of death for males, has decreased about 10 percent between 1968 and 1973 for men in each 5-year age group between the ages of 25 and 75. However, in men between ages 15 to 29 we do not see an overall mortality decrease. In this group, the vast majority of deaths result from accidents, homicide, and suicide, and while deaths from accidents have remained relatively stable, those from homicide and suicide have increased.

SUICIDE AND INFANT MORTALITY RATES

Mr. FLOOD. A marked increase in suicides within that age bracket?

Dr. COOPER. We have steady increases, sir.

Infant mortality continues to decline from a rate of 29.2 per 1,000 live births in 1950 to 16.5 in 1974. However, for infant mortality, the United States still ranks 15th among the countries of the world.

Mr. FLOOD. Is that good?

Dr. COOPER. Not particularly. The lowest is 9.6, in Sweden, per 1,000 live births.

Mr. FLOOD. That was a leading question?

Dr. COOPER. Yes, sir.

In all these cases, sir, I would point out parenthetically that although we are making progress, there are large numbers of problems yet that remain to be resolved.

The infant death rate for nonwhites continues to run considerably higher than for whites in this country. As an indicator of the status of health in this country, the infant mortality rate is still unacceptably

high. While our efforts have produced a slow but steady decline in this rate over the last decade, the incidence of births of children with low weight or premature infants is the same as in 1950. We plan to coordinate the efforts and resources of departmental programs toward reducing premature births, with the hope of achieving a reduction in our infant mortality rates. As part of its overall concern of prevention, the Department will continue, through its various programs, efforts to increase immunization levels among children, thus reducing the incidence of communicable diseases.

The number of women who die in childbirth has also been declining. In 1950 the rate was 83.3 and in 1974 it was 20.8 per 100,000 live births. Here again, though, maternal death rates for nonwhites are considerably higher than for whites—about three times higher.

Mr. FLOOD. You use the term "nonwhites." You mean more than blacks?

Dr. COOPER. That is right, it covers blacks and all other nonwhites. Here again, though, maternity death rates for nonwhites are considerably higher than for whites. The incidence in the nonwhites is about three times higher.

DECLINE IN BIRTH RATE

Another dramatic change that is occurring in our population is the decline in the birth rate. In the early 1950's, the birth rate was 25 per 1,000 population and, in 1974 it has dropped to 15 per 1,000. Total births in the country have dropped from 4 million annually in the late 1950's to near 3 million annually in 1974. We can expect that the dynamics of the changes in the birth rate will continue to have a major impact on the functioning of our health, educational and social institutions.

INCREASE IN NURSING HOME POPULATION

Over the same period during which we have been experiencing the decline in mortality and birth rate, there has been an appreciable increase in the number of people residing in nursing homes. On an average date in 1964, there were approximately one-half million residents in nursing homes, by 1969 this number had grown to three-quarters of a million and by the end of 1973 the number was over a million. While a portion of the growth is due to the increasing numbers of elderly in our population, this factor does not account for the total change. Nor is there reason to suspect that older people today are less healthy than they were in the past. We are witnessing changes in the mode of care for the elderly ill resulting from changes in life style, attitudes, and the availability of financing for nursing home care under medicare and medicaid.

Mr. FLOOD. Attitudes?

Dr. COOPER. Yes. I think that more people now are aware of the possibility of having their elderly relatives cared for in an institution, and because of availability of financing, they then elect to institutionalize the people rather than care for them at home.

Mr. MICHEL. Private homes or their own homes?

Dr. COOPER. In their own homes; yes, sir.

In addition, we find that because of the great awareness and expectations of modern medicine, many families feel that the elderly can be benefited by selective methods of treatment that previously may not

have been available to them. We find a larger number of people over 65 are benefiting from major operations. For example, the cardiac pacemaker, renal dialysis, and even some greater forms of therapy like coronary artery bypass.

I think the whole attitude of what one can expect from medicine in health care has undergone a great deal of change.

This year we conducted a nationwide survey of 295 skilled nursing facilities participating in medicare and medicaid programs.

Definitions of Medicaid and Medicare

Mr. Flood. At this point, for the record, will you devote a couple of paragraphs to the definition of medicaid, as distinguished from medicare?

Dr. Cooper. Yes, sir.

[The information follows:]

In response to the question of what is medicaid and how does it differ from medicare, I have outlined the differences below:

MEDICAID	MEDICARE
A. Designed for certain kinds of needy and low income people: The aged (65 and over). The blind The disabled. Members of families with disabled children. Some other children. Some States also include (at State expense) other needy and low income people. Some people can have both medicaid and medicare.	A. For almost everyone 65 or older whether rich or poor. It also protects disabled people who have received social security disability payments for at least two years.
B. Is an assistance program with funds derived from Federal, State, and local taxes for eligible people.	B. Is an insurance program with money derived from trust funds for insured people.
C. A Federal-State partnership which varies from State to State.	C. A Federal program which is the same throughout the United States.
D. Medicaid pays for at least these services: Inpatient hospital care. Outpatient hospital services. Other laboratory and X-ray service. Skilled nursing facility service. Physicians services. Screening, diagnosis, and treatment of children. Home health care services. Family planning services.	D. Medicare provides basic protection against costs of: Inpatient hospital care. Posthospital extended care. Posthospital home health care.
E. In many States, medicaid pays for such additional services as dental care, prescribed drugs, eye glasses, clinic services, intermediate care facility services and other diagnostic, screening preventive and rehabilitation services.	E. Medicare provides supplemental protection against costs of physicians services, medical services and supplies, home health care services, outpatient hospital services and therapy and other services.
F. Is financed by Federal and State governments.	F. Medicare hospital insurance is financed by a separate payroll contribution; and the medical insurance is financed by monthly premiums paid by the Federal Government and the insured person.
G. Is run by State governments within Federal guidelines.	G. Is run by the Federal Government.

Dr. COOPER [continuing]. An interim report on the study reveals a wide variance in the degree to which nursing home providers comply with standards required by medicare and medicaid. The report noted that two-thirds of the nursing homes surveyed had several life safety code deficiencies, most of which could be corrected at little cost. This code deals primarily with fire hazards. Also noted in the report was that patients are not visited by their physicians as often as required, and that tranquilizers were possibly misused since more than 40 percent of the patients in the survey had tranquilizers prescribed for them.

Mr. FLOOD. What do you mean by "not visited by physicians as often as required"? By whom and what?

Dr. COOPER. As would seem necessary for their current state of health, as a standard of practice.

Other implications of the report dealt with inadequate nutritional practices, lack of rehabilitative services, and need for better training for nursing personnel. This survey provides valuable data to those programs in the Department which are responsible for improving standards and practices in long-term care facilities.

PUBLIC HEALTH SERVICE BUDGET OVERVIEW

The 1976 budget had to be developed before the final enactment of legislative authority for several programs, and before the final level of the 1975 appropriations had been determined. We still do not have authorizing legislation for the comprehensive formula grants and for many of our manpower programs, and a number of health services delivery programs. The budget submitted to you by the President in early February was prepared on the assumption that the proposed rescissions of $516 million for the health programs would be approved by Congress. Since these rescissions were rejected, we will obligate the funds this year. The awarding of additional grant projects in 1975 will generate increased continuation requirements in 1976. In the coming months, we will evaluate our grant programs on a project-by-project basis to determine how and where these additional costs will be accommodated within the 1976 funding totals. For example, we anticipate that some lower priority ongoing projects will receive less funds than originally planned, or perhaps will be terminated altogether. Additionally, the number of new and competing projects which have been proposed to be initiated in 1976 will probably be reduced. Since we do not yet have precise figures on how this can be best accomplished, the justifications before you do not reflect final decisions as to the distribution of new and continuation projects for the funds available within each appropriation.

I think it would be helpful in understanding the 1976 budget estimates for the programs of the Public Health Service if I review the major principles and guidelines followed in developing the budget.

NON-FEDERAL CONTRIBUTIONS

The budget reflects the decision to require States, local governments, and private institutions to contribute a greater share toward the cost of the health care delivery programs that the Federal Government has been supporting by grants and contracts.

The application of this policy will result in a reduction of $157 million in the Federal support for community health centers, maternal and child health programs, migrant health projects, family planning projects, the venereal disease control program, and immunization project grants. This policy is based on the belief that the primary responsibility for operating these projects belongs to State, local, or private, nonprofit agencies; and the role of the Public Health Service is to help these organizations through financial and technical assistance to establish the capacity to provide medical services effectively. In the future, the Federal support for health service programs will come increasingly from the medicare and medicaid programs, and later on from national health insurance. If the anticipated increased contributions from non-Federal sources are forthcoming, this will permit the same level of services to be maintained in these programs in 1976. Achieving this goal will require that State and local governments consider a reordering of priorities to assure that adequate funds are made available to these health programs. It should also provide incentives to these agencies to maximize the reimbursement of costs from third party payers.

Mr. FLOOD. You prefer reordering? You don't like the motheaten realignments of priorities? You are going to reorder them?

Dr. COOPER. We should have a new phrase for each year.

An additional $90 million reduction in our budget resulting from the application of this policy is the proposed termination of the comprehensive health formula grant program. The legislative authority for this program terminated on June 30, 1974, and its extension will not be proposed. It is being carried out in 1975 under the authority of the continuing resolution, and no funds are requested in 1976 for its continuation. This grant program has provided financial assistance for basic public health activities at the State and local level.

EMPHASIS ON IMPROVING HEALTH CARE DELIVERY

The budget reflects a greater emphasis on those programs which are directed toward bringing about change or improvement in the Nation's health care delivery system.

During the period of 1950 to 1974, we have seen total health expenditures in the United States rise from $12 billion to $104.2 billion, and, at the same time, the public share of this cost has risen from 26 percent to 40 percent. This continued increase makes it all the more important that we foster changes in our health care system to assure greater access for all people to the high quality medical care for the least cost. The Federal role in bringing about this change is not to become the regulator of the health industry, but rather to create the regulatory forces within the health care system to assure good medical care at the lowest cost.

Several of the public health services programs are aimed at achieving this goal—the professional standards review organizations, health maintenance organizations, emergecy medical services, and our health services research programs.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. FLOOD. At this point in the record translate that PSRO. You might put a paragraph or two in on what is such a thing.

Dr. COOPER. Yes, sir.

[The information follows:]

The Professional Standards Review Organization (PSRO) legislation was enacted as part of the Social Security Amendments of 1972, Public Law 92-603. PSRO's are designed to improve the existing utilization review (UR) requirements of medicare and medicaid where utilization review is a condition of participation for health care institutions which receive reimbursements from these Federal programs.

The intent of the PSRO amendment is to foster the creation of locally sponsored, locally administered physician organizations which will have full responsibility for the review of medical care provided under the Social Security Act for quality, necessity, and appropriateness. Previously, these decisions were made by fiscal agents and intermediaries. The PSRO's will implement this responsibility through the application of professionally developed criteria and peer review techniques.

Dr. COOPER. Through this program a mechanism is provided for local physicians to review and upgrade the level of medical care they provide according to standards which they establish. A nationwide network of voluntary, nonprofit groups of local physicians will be established to assure the quality and appropriate utilization of health care services financed through the medicare, medicaid, and maternal and child health programs. In 1976 we are requesting $50.1 million for PSRO activities, an increase of $13.9 million over 1975.

HEALTH MAINTENANCE ORGANIZATIONS

Another change which we believe will result in more effective and less costly health services is the development of health maintenance organizations which provide comprehensive health services on a prepaid capitation basis. In 1976 the emphasis in the HMO program will be on certifying existing HMO's and increasing the enrollment of members of HMO's through the greater acceptance of the dual option provision by employee groups participating in health insurance plans. Our proposal for the health maintenance organizations in 1976 is $18.6 million, compared to $8.3 million for 1975.

EMERGENCY MEDICAL SERVICES

We have long been concerned about the inadequacy of our health care system to respond rapidly and effectively to people requiring immediate emergency medical attention. Through our emergency medical services program, we are supporting projects to demonstrate how communities can bring about changes in their health care systems by developing comprehensive arrangements of trained personnel, medical facilities, and equipment to respond to emergency medical situations.

In 1975 these were 57 programs. In 1976 there will be in operation 76 emergency medical services system which have received support from the Public Health Service. These systems will serve a potential population of 38 million persons. The 1976 level of this program is $25.1 million, compared to $37 million in 1975.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

Through our National Center for Health Services Research, we conduct studies on new techniques to improve the way we manage and finance the Nation's health care activities. These include the development of new approaches to increase productivity and reduce costs,

placing greater emphasis on the use of nonphysician manpower, and integrating chronic illness health care more effectively and efficiently into the rest of the health delivery system. In 1976 we are requesting $26 million for these activities.

Malpractice Insurance

A serious problem which affects both the cost and quality of health care is the crisis in the availability of malpractice insurance for physicans. Insurance companies that have been writing malpractice insurance are finding the business unprofitable because of the increase in the number of suits and the size of the final judgments, and in several States, the companies are threatening to stop writing insurance. If physicians cannot buy insurance, they may have to cut back on their practice. This is a very complex problem which does not lend itself to a single solution. Secretary Weinberger has asked that companies delay any precipitous action until all parties involved—the doctors, hospitals, insurance commissions, lawyers, and the insurance companies—have a chance to work out solutions.

Mr. Flood. Are there any States as of today where the insurance companies have cut off coverage?

Dr. Cooper. Not effective as of this date. There are several States in which there is a date set in the near future. That is within a month in some cases.

Mr. Shriver. Are there not some States not issuing insurance to new physicians?

Dr. Cooper. This will be so as of 5 or 6 weeks. Usually the insurance companies have indicated either that they will increase rates or decrease the service entirely or decrease the service to new physicians entering the program, or a combination of all three.

Mr. Flood. And hospitals?

Dr. Cooper. And for hospitals as well, though mostly physicians at this time. In some States where the insurance commissioner has rejected the rate increase request, these have precipitated judgments by the companies that they have to terminate service in the State entirely.

Under the National Center for Health Services Research, we will be initiating specific studies to explore various aspects of the long-term solution to this problem. The immediate short-term problem is the availability or access to insurance for physicians and other providers.

Mr. Flood. Don't you have insurance for lawyers in case they don't get a verdict?

Dr. Cooper. Not yet. Another aspect of the problem, Mr. Chairman, and one which is part of the debate that is going on concerns the contingency fee concept and the tort concept. Perhaps these concepts need to be reviewed in this connection.

Improvement of Health Statistics Data

Dr. Cooper. In 1976 we will continue to emphasize the development of better statistical health data. Without reliable data on the health of the American people, the health care they receive, and the ways in which that care is delivered, it is difficult to plan and budget ade-

quately for health care activities. Thus, sound health statistics are essential, not only at the national level, but also for the regional and local levels, where a variety of health planning and regulatory decisions are made and carried out.

In 1976 we are requesting $25.6 million, an increase of $3.6 million, to expand our health statistical activities. Emphasis will be on building each State's capacity to collect and process data on health manpower, health facilities, utilization of health services, and health status of the population so that comparable statistics can be produced for use at the Federal, State, and local level.

CONTINUED SUPPORT FOR BIOMEDICAL RESEARCH

The 1976 budget provides for the continued support of biomedical research.

Biomedical research and training continues to be one of the most significant activities of the Public Health Service. The total proposed budget in 1976 for the National Institutes of Health is $1.8 billion, or 40 percent of the proposed Public Health Service budget. We are requesting $605 million for the National Cancer Institute, $293 million for the National Heart and Lung Institute and $907 million for the remaining institutes and divisions.

Mr. FLOOD. For the record, break that down by Institutes.

Dr. COOPER. Yes, sir.

[The information follows:]

The 1976 budget requests for the National Institute of Health are as follows:

	In millions and tenths
National Cancer Institute	$605.0
National Heart and Lung Institute	292.8
Subtotal	897.8
National Institute of Dental Research	43.5
National Institute of Arthritis, Metabolism, and Digestive Diseases	148.4
National Institute of Neurological Diseases and Stroke	115.0
National Institute of Allergy and Infectious Diseases	108.7
National Institute of General Medical Sciences	161.6
National Institute of Child Health and Human Development	106.1
National Institute on Aging	16.2
National Eye Institute	39.2
National Institute of Environmental Health Sciences	31.1
Research Resources	81.1
John E. Fogarty International Center	4.5
National Library of Medicine	28.8
Building and Facilities	3.0
Office of the Director	20.0
Subtotal, other research institutes and divisions	907.2
Total, National Institutes of Health	1,805.0

HEART AND LUNG INSTITUTE FINDINGS

Dr. COOPER. I would briefly like to mention a few of the significant research findings during the past year. Scientists in the National Heart and Lung Institute have made major advancements in studying the mechanism and regulation of protein synthesis in human red blood cells in man. Specifically, they have worked out the

steps used by the red cell in making hemoglobin and have begun to understand the ways in which the cell controls the amount and type of hemoglobin made. The understanding of this process is of great importance to learning more about the causes of blood diseases such as Cooley's anemia and sickle cell anemia.

Cancer Research

National Cancer Institute scientists have reported the isolation of a virus from the laboratory-grown leukemia cells of a 61-year-old woman with acute myelogenous leukemia. This is a cancer of the blood which interferes with the proper development of white blood cells. Isolation of the virus provides scientists for the first time with a human virus that may be useful in identifying the one or more factors that cause this form of leukemia. Studying this virus also may enable scientists to develop new approaches to detection, diagnosis and treatment of human leukemias.

The National Cancer Institute is investigating the use of a postoperative drug treatment in women suspected of having residual metastatic cancer. After 2 years of study, it has been shown that the rate of cancer recurrence is significantly reduced for women receiving L-phenylalanine mustard (L-PAM), an oral anticancer drug. One out of 30 premenopausal women patients receiving L–PAM had recurrence, compared with 11 out of 37 receiving surgery but no drug. Recurrence rates were also reduced for postmenopausal women but not as markedly.

Arthritis and Diabetes Activities

The 93d Congress authorized expanded activities in arthritis and diabetes programs of the National Institute of Arthritis, Metabolism, and Digestive Diseases. National commissions have been established to develop long range plans with specific recommendations for the utilization and organization of national resources to enable an effective followthrough of research opportunities in these disease areas. The reports of these commissions are to be presented in late calendar 1975.

In these particular areas, I might say the science also offers a great deal of promise for expanded areas in understanding their impact on the state of health of the American people, particularly in diabetes, where the linkage with heart disease is so prominent. Perhaps 50 to 75 percent of the people that have arteriosclerosis also have diabetes, and the metabolic linkage here may be a most important contribution not only to the control of diabetes but control of heart disease as well.

We are looking forward to the findings of the Commission as well as that of the Arthritis Commission. The area of arthritis research is also one in which a great deal of recent scientific and clinical advancement has been made.

The President's Biomedical Research Panel has been established and is engaged in the performance of its mandate to review, assess, and make recommendations concerning biomedical and behavioral research conducted and supported by the Federal Government. The panel is charged to provide the President and Congress a report on its findings and recommendations at the end of 15 months of study and deliberation. We expect this report by the spring of 1976.

We are looking forward to receiving the findings and recommendations of these study groups to advise us on the research opportunities which will be most promising to pursue.

Commission on Protection of Human Subjects

I might add also, that to advise us on the guidelines on the protection of human subjects in research, a national commission has been established on human ethics. That Commission is currently quite active. The initial recommendations of this group which will deal with fetal research, are due to the Secretary on May 1, and they are currently on schedule.

Diseases and Disorders of the Heart

Mr. Flood. At that point give us a paragraph for the record with reference to the term "heart disease." That is a very common term, and always has been. The term "disease" in the mind of the public is concerned with a germ or infection of some kind. Would you indicate what you mean by that term?

Dr. Cooper. We do mean many things. Some diseases are caused by germs, others by functional impairment but we will distinguish them.

[The information follows:]

The phrase "heart disease" is used to refer to a mix of several different diseases, some of which are related to each other. The most common and most serious single disease is arteriosclerosis or "hardening of the arteries" which underlies heart attack and heart failure and is the cause of four-fifths of the deaths from diseases of the heart and blood vessels in this country. It forms the basis of almost half of the deaths from all causes.

The next most common cause of heart disease is hypertension or high blood pressure. Hypertension is an important factor in the development of heart attacks and heart failure. The heart becomes diseased as a consequence of high blood pressure, whatever the underlying cause of that elevation of pressure. Coronary heart disease results from the hardening of the arteries that supply the heart muscle. Such changes also may lead to angina pectoris (a pain in the chest and left arm brought on by exercise, exposure to cold and other factors), as well as disturbances of heart rhythm and in some cases sudden death. Arrhythmia or abnormal heart rhythms is a common manifestation of a variety of types of heart disease and contribute to heart failure and to death. Several forms of heart disease are related to structural changes in the heart, as in a variety of congenital abnormalities and changes in the heart valves due to rheumatic fever. A less frequent but still important group of diseases are the "cardiomyopathies" and infections of the heart which affect the heart muscle and its lining. Causes may include toxic materials, viral infections, alcohol intake, immunologic reactions, nutritional deficiencies, and others. Inflammation of the heart wall or its internal or exterior surfaces may be caused by viruses, bacteria, or fungi. It is because so many of the different diseases of the heart manifest themselves in functionally similar ways that it has been convenient to refer to them as a group with the phrase "heart disease."

New Health Manpower Policy

Dr. Cooper [continuing]. The 1976 budget reflects a continuing effort to change the role of the Federal Government in funding the training of health professions and medical research personnel. The health manpower authorizing legislation expired in June of 1974, and we are requesting $339 million in 1976 to cover the requirements for the legislation proposed by the President.

Institutional assistance including capitation grants will be funded at a level of $116.9 million in 1976, reflecting the policy of gradually phasing out capitation support.

Capitation Grants

Mr. Flood. Indicate for the record what you mean by "capitation grant."

Dr. Cooper. Capitation is that form of assistance to the institution which is calculated on the basis of the number of students that they have matriculating, a given number of dollars per student is given. Originally it was given, as I recall, in 1966, with modifications made in 1970 and 1972, as a grant to an institution to contribute toward the educational process. There have been increasing indications more recently that both the Congress and the administration would feel that if this policy continues, some specific activity in the medical institution or objective ought to be fulfilled through awarding this type of capitation support.

Student assistance support of $67.5 million is requested, including funds for National Health Service scholarships and repayment of educational loans for doctors who are practicing in medically underserved areas. Traditional direct loan and general scholarship programs, which do not require public service from recipients, will be phased out. We are requesting $155 million, an increase of $50 million, for special project grants to increase the number of primary care physicians, increase educational opportunities for physicians and dental extenders, and try to solve the problems of geographic maldistribution of health professionals.

Health Professions

Mr. Flood. What is a dental extender?

Dr. Cooper. This is a health professional, not a dentist, who has not gone through the educational process of acquiring a dental degree and dental licensure, but can perform for the dentist some of the important features of dental care under his supervision.

Mr. Flood. That is what we in the Defense Department call paramedics?

Dr. Cooper. Yes, sir.

Mr. Flood. What is a primary care physician?

Dr. Cooper. A primary care physician is a physician who is available to a citizen to address his complaints at the onset of his illness, irrespective of the type of illness. He is generally competent in the areas of internal medicine for adults or pediatrics for children, obstetrical and gynecological capability for certain of the women's conditions, and emergency medical care for others. Also, he may be competent in some forms of behavioral or psychiatric care.

Mr. Flood. That includes what we call the family physician, general practitioner?

Dr. Cooper. It is often called that. It depends in some respects whether you see them first or whether they are offering total family care, what the nuance of the clarification is.

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It is the concept of being able to see a physician who can assess your needs and, if necessary—and only if necessary—refer you to special care.

Reduction of Alcohol, Drug Abuse, and Mental Health Programs

The 1976 funding request for the alcohol, drug abuse, and mental health programs continues the gradual reduction of Federal participation.

We are requesting $654 million for the Alcohol, Drug Abuse, and Mental Health Administration, a decrease of $163 million from the 1975 level. In the mental health services area we plan to continue the current policy of relying on the States to develop new treatment programs. We believe that the concept of community-based mental health care has been amply demonstrated and the community mental health centers should be able to obtain operating funds through State and local contributions as well as through reimbursements from patients or third party payers. Therefore, support for new community mental health centers will be limited to continuation funding for existing centers. A total of 626 of these centers has been funded through 1975 and by the close of 1976, 543 of these will be operational.

The level of research programs has been reduced below 1975, but we will continue to emphasize high priority mental health, drug abuse, and alcoholism research projects.

The drug abuse community assistance program request for 1976 is $173 million, and these funds would be used to maintain the support of 95,000 drug abuse treatment slots in various projects throughout the country. Assistance to communities for alcoholism treatment, rehabilitation, and prevention would be supported at a level of $91 million.

National Health Planning and Resources Development Act of 1974

An important new direction in the 1976 budget is the implementation of the recently enacted National Health Planning and Resources Development Act of 1974.

This act replaces the comprehensive health planning program, the regional medical programs, and the Hill-Burton medical facilities construction program. It establishes a new system of State and local planning agencies and a new grant program to assist in financing construction of medical facilities. During 1975 we have requested $75 million to fund the transition of the old agencies into the new planning agencies, and in 1976 we are requesting $175 million for this new legislation. We plan to designate and fund 200 new health system agencies, finance the first year cost of 28 State health planning and development agencies, develop improved methods and technology for health planning, and provide technical assistance to the new planning agencies. Formula and special project construction grants will be made to modernize outdated hospital beds, construct outpatient facilities, and assist publicly owned facilities to meet safety standards or creditation and licensure requirements.

Mr. Flood. In all those matters, the application must first be filed by the concerned party?

Dr. COOPER. Yes, sir.

In summary a total of $4 billion in new budget authority is being requested in 1976, a decrease of $900 million from the comparable level of $4.9 billion in 1975.

I shall be pleased to answer any questions you may have.

REDUCTION FROM 1975 LEVEL

Mr. FLOOD. I don't blame you.

The 1975 budget for the health programs that you now have before the committee totals $4,030,326,000. I didn't think I would live that long. That is a reduction, however, of $808,756,000 before the 1975 appropriations for these programs. That is $840,718,000 below the 1974 appropriations. You have been around and you are no beginner here and you know this situation. We feel pretty certain, we have reasonable cause to believe that if we were to take this budget proposal on the House floor we would be pretty severely attacked on this business of agreeing to a 20-percent reduction or cutback in dollars for these health programs during this period of inflation.

As you heard me say, you will be sitting up there in the balcony with your cast of characters, after a good lunch, and we will be down in the well. How can we defend ourselves from that kind of an attack?

Dr. COOPER. I think you could take two approaches, Mr. Chairman.

Mr. FLOOD. Is that all?

Dr. COOPER. One is based on the fact that the actual proposal, when it was conceived, included a strategy which involved the 1975 funds as well as the 1976 funds. In many instances the impact on the programs that are involved was not really as severe a reduction as they may now seem. In selected programs, there were substantial increases in 1975 because the Congress elected not to accept the rescission recommendations made a couple of months ago.

The total operating strategy over the next 15 or 16 months really does provide for some activity that would be different from the appearance of just a straight cutback in program activities or that steep a cliff. I think the more important aspect of the overall health strategy that needs to be addressed——

Mr. FLOOD. Point No. 2?

Dr. COOPER. Yes, sir. The most important aspect of the strategy that needs to be considered is that the objective of all of the programs is really the health of the American people, and one cannot view this particular part of the overall U.S. budget alone or as the only part that impacts on the health of the American people. There have been other significant changes in the distribution of the total Federal budget and budget allocations that are directly relevant to the health of the people, particularly during this period of inflation and recession. I have particular reference to the expected increases of significant proportions in unemployment payments that have gone up twofold and threefold and expected to reach $16 billion compared to a level of $12 billion, and previously perhaps only $6 billion.

The health of the people depends not only on the availability of health services and new treatment but on the basic human requirements to eat and to be gainfully employed. I think a certain part of our strategy is that we have to think totally as to what are the national re-

sources going to meet the human condition. If you add all those situations up and trade them off, you might be willing to consider the difference in allocation, for a period of time at least, for the total objectives of even the Public Health Service.

Mr. FLOOD. I won't pursue that generic question much further now. All the questions that you will hear from the committee from now on will somehow or other directly or indirectly touch upon that basic question, I am sure. If I don't pursue it now with you, don't think that you have knocked me off the chair with those two answers.

Dr. COOPER. Yes, sir, I understand.

FIVE-YEAR FORWARD PLAN FOR HEALTH

Mr. FLOOD. Doctor, I understand that you and your staff developed what you call a 5-year forward plan for health?

Dr. COOPER. Yes, sir.

Mr. FLOOD. Does this budget before us reflect the major initiatives that you propose in this forward plan?

Dr. COOPER. May I answer that question yes and no?

Mr. FLOOD. Then go on.

Let me help you. Can you identify for the committee the major health initiatives that you propose in this forward plan for fiscal year 1976?

Dr. COOPER. Yes, sir. There are five major themes that we thought ought to be emphasized. Keep in mind that there are, as you know, somewhere in the order of 165 and 179 specific programs in the Public Health Service as a whole and what we really were trying to develop in this forward plan is a fabric for discussion of what are the major items that the public, the professions, and the Congress needed to consider. There were five. There were two in one category and three in another. The two in the first category were the continued support of research, and I have already spoken to that. It is increased productivity, and increased need.

The second that I have already spoken to, is the modernization of our statistical system to make it a dynamic health accounting system, not a morbid vital statistical system. That is provided for in this particular budget request, along with making it interdigiate more effectively with the State and local statistical systems.

The other three are emphasis on prevention, quality assurance, and what we call in that document, preparing for national health insurance, which was shorthand for saying modifying the system or preparing the system for the structural changes which would be needed to serve a greater number of people with a comparable level of quality service. This includes manpower questions, planning questions, and the regulatory questions, the question of primary care, and so on.

To the extent that this budget, and this is the "yes" part of my answer, provides for selected increases, it does reflect initiatives proposed in the plan.

It does speak to increased statistical needs. It does speak to the emphasis on the need for quality assurance mechanisms and their development, and these have been suggested. There is also a specific request in here for primary medical care, the emphasis on prepaid health service as a competitive alternative.

The "no" in it is that it is true in the presentation which was made and developed a year ago—before the economic crisis and before the instructions from the President on the budget constraints—the amounts proposed in the plan represented an ideal number for us to proceed. This is as we saw it last spring. The 1976 budget does not reflect those numbers.

Mr. FLOOD. In what way does this budget that you are talking about today deviate from this forward plan in 1976?

Dr. COOPER. The main deviation is in our estimates of what we would have thought would have been an appropriate amount to spend if the national resources permitted it. They were considerably higher than what we are proposing today. That is the main difference.

Mr. FLOOD. Would you be kind enough to provide each member of the subcommittee with a copy of this forward plan?

Dr. COOPER. Certainly.

TERMINATION OF COMPREHENSIVE GRANTS TO STATES—SECTION 314(D)

Mr. FLOOD. Your budget calls for termination of 314(D). That is the comprehensive health grants to the States. As I understand it, the purpose of these grants is to assist the States in establishing and maintaining adequate public health services. That seems pretty important to us.

How do you explain this proposed termination of the program? You must be Houdini. How did you do that?

Dr. COOPER. I would explain it on this basis, Mr. Chairman: The actual amount of money that was previously going into the 314(D) grant program was $90 million per year. This is a considerable amount of money, I recognize, but on a percentage basis, of the total State operation, it is about 4 percent of the total operations of the State systems. I recognize that that kind of margin can be very important. However, these particular funds were used in a wide variety of ways to support State public health systems.

They were not uniformly used throughout the States, and we felt that in view of the amount of funds that were available to us for distribution, if we had to try to guess or calculate or plan what the greatest productivity was that we could get for the Federal dollar, that the yielding of this particular 4 percent of the States' total health budgets could be more profitably spent in some other category.

STATES' RESOURCES

Mr. FLOOD. The budget calls for States to absorb a much larger share of the costs of the direct health care programs, such as the maternal and child health services. We spent all these years with you sitting there and these programs, you say, must be continued. Believe me, we keep hearing from all the Governors of the States and everybody else that they simply don't have the money. That is the point.

If we were to approve this budget, isn't it possible—probable—that a lot of these people who need this medical aid will simply not get it?

Dr. COOPER. It is possible.

Mr. FLOOD. Probable?

Mr. COOPER. I couldn't speak for the States in this regard.

Mr. FLOOD. I don't want you to speak for the States. You are pretty good, but even you could not do it.

Dr. COOPER. If I said probably, I would be making a judgment on the State allocation. That is where the actual decision would be made as to how State resources could or would be adjusted to meet public health needs that were not being covered by the previously available Federal share of dollars in all these programs.

Mr. FLOOD. Isn't it true that because of the current economic situation many more people are turning now to these federally supported direct care programs for whatever medical care they are going to get?

Dr. COOPER. There has been an increase in utilization.

Mr. FLOOD. The answer is "Yes"?

Dr. COOPER. Yes, sir.

Mr. FLOOD. Capital letter?

Dr. COOPER. Yes, sir.

CONTINUATION GRANTS

Mr. FLOOD. Does this budget before us for NIH provide NIH with enough money to meet the costs of awarding all of the noncompeting continuation grants?

Dr. COOPER. The answer is "No."

Mr. FLOOD. Do you have any idea at all of how much more money will be needed in order to meet these awards, all of these noncompeting grants?

Dr. COOPER. The shortfall by our calculation would be 3 percent or about $40 million, providing that we eliminated all the "new starts" proposed in the original 1976 budget.

Mr. FLOOD. If we were to approve the budget, what would be the impact on the ongoing research activities?

Dr. COOPER. If you were to approve the budget, Mr. Chairman, our recommendation would be to recognize and authorize the need to adjust some continuation of support so that the previous project commitments for continuation could be adjusted downward to account for the shortfall in the first hand, and second, to provide for some additional funds to be available for new awards. We would ask you for permission to readjust the distribution of the funds between continuation and new grants that were in the original justification to allow us to determine the appropriate mix of continuation support and new awards.

PREDOCTORAL RESEARCH TRAINING AT NIH

Mr. FLOOD. Here is one I don't think you will be surprised to have me ask you. It appears once again the predoctoral research training program at NIH seems to be in a state of confusion. Will you explain to the committee the departmental policy on this predoctoral research training?

Dr. COOPER. The current policy of the administration on predoctoral training is that, first, we recognize that predoctoral training will have to go on. It is a necessary part of the educational and training process. Second, that the Federal support of the activity should be terminated and the funds available for training should be applied, during this

period of fiscal restraint, for postdoctoral training. It is in this particular time that the specific focusing on selective shortage areas can be best accomplished.

Mr. FLOOD. If we were to go along with your proposal, phase out this training that we are talking about at NIH, where would the support come from for the future manpower?

Dr. COOPER. I think there are three general categories from which support at this level would come, Mr. Chairman. One is from undergraduate training support from the educational office.

Mr. FLOOD. Educational office?

Dr. COOPER. Office of Education.

Mr. MILLER. Graduate support in the form of loans.

Dr. COOPER. Mr. Miller mentioned, and I agree, that the Office of Education guaranteed loan program is a source. Also, the basic opportunity grant from the Office of Education, and there are some private funds of a limited amount that come to certain institutions for the support of training. I would mention a fourth. The fourth is that even before the mid-1950's, when the large training grant program was begun at the National Institutes of Health and the National Institute of Mental Health, students and graduate students were trained by working on research projects that were supported through the research grant funds.

We have no proposal to terminate that particular kind of direct participation and reimbursement for this specific training activity, so I don't think all forms of support for this level of training would be eliminated by the proposal.

COMMUNITY MENTAL HEALTH CENTERS

Mr. FLOOD. This budget calls for substantial reductions, and I mean substantial, in mental health activities, and the emphasis all through the presentation seems to be on greater reliance for any operational funding from third party reimbursement.

What hard data do you have to back up your position that third party reimbursements are going to be sufficient to support the development and the operation of these community mental health centers?

Dr. COOPER. Let me take a try at that by two kinds of specific comments, Mr. Chairman.

One is that the staffing grant which currently supports the community mental health center accounts for about 23 to 30 percent on an average of the total operating costs of the center at the present time. Consequently I think there is good evidence that non-Federal funds are a very large factor and an important one for the support of the activities of this particular program. Thus, a change in that type of commitment is not a new or innovative idea in this particular program.

Second, we have been pursuing a management objective within the Department during the last couple of years in which we were trying to provide technical assistance and help to all these service programs to develop their capability of obtaining, when it is available, third party reimbursement.

We have been able to make some progress in that direction and our overall experience in that regard is that we have improved our position by about 13 to 17 percent. Again I can't guarantee that we could

deliver the net figure, which was our target in our budget, of 20 percent but I do think we have some reason to think that it is a reasonable objective.

SRS Reimbursements to Mental Health Centers

Mr. Flood. Doctor, we understand that while you are attempting to increase reimbursement, as you say, from these third parties, that the social rehabilitation service at HEW published a regulation concerning certain reimbursements to these mental health centers and it runs very much counter to your efforts, so it seems to us.

Can you explain the situation to the committee. What effect will they have on the reimbursements to be collected in this 1975 budget? I am talking about title IV(a) and VI.

Dr. Cooper. I understand and I know the problem, Mr. Chairman.

Mr. Flood. I am sure of that.

Dr. Cooper. And I am trying to formulate in my mind here a crisp way of explaining this, if I may. It was the concern of the SRS that the Department not be put in a position of double funding the same activity through different agencies of the Department. It became necessary to try to seek clarification of what portion of calculated costs for the operation of a federally funded clinic, should be reimbursed by SRS based on the total sources of revenue of the clinic.

The difference of opinion that arose concerns the manner in which the community mental health staffing grants and the State matching funds are considered in determining the base of calculation for reimbursement under the title IV–A program.

I think this is a complex issue.

Mr. Flood. You see our position.

Dr. Cooper. Yes.

Mr. Flood. Here is the doctor's statement over here. Then here is this SRS.

Now, I dare you.

Dr. Cooper. Against the background, and if I could throw in one other factor, which is that these are declining grants as well—the Federal share goes from 90 percent down to a lower level—there is a need for regular recalculation. The concern of the community naturally would be how to, with some degree of certainty, calculate what the reimbursable situation might be.

The SRS is responsible for the management of the outflow of the medicaid and social service funds and is seeking to cut costs by eliminating possible fraud and duplication. The health sector has the responsibility of trying to maximize the self-sufficiency of the health system.

We are going to push them very hard to try to get as much resources as we can from that source of revenue besides our direct funds. It is not a surprise to me that they will look at us very hard for the demands we make on the reimbursable funds from that other agency.

Mr. Flood. It is going to be eyeball to eyeball.

Dr. Cooper. Yes, sir. And we will continue to negotiate that with them and perhaps clarify that particular situation in the near future.

Mr. Flood. We are standing there ringside.

Mr. Miller. Mr. Chairman, let me add this, though.

In case we appear to have two parts of the Department going down separate tracks with no point at which they are finally put together, this is a matter which the Secretary has on his desk and we will issue something that brings the two together. The Secretary will determine whether the SRS regulations or the attempt to maximize third party payments is going to take precedence in our internal policy.

Mr. FLOOD. By the time this gets to the other body you will have all the answers?

Mr. MILLER. Actually we are fairly close to it.

Mr. FLOOD. Mr. Michel.

EFFECT OF DENIAL OF PROPOSED RESCISSIONS

Mr. MICHEL. Dr. Cooper, several weeks ago some of us tried the best we could to support your position, at least in part, on the rescissions that were proposed and, as you well know, all our efforts went down in vain and the Congress turned you down on all of them. This means you are going to really have to spend a lot more money in fiscal year 1975 than you had planned if you were serious about the rescissions that were being proposed.

Does that have any kind of bearing now in the presentation of your 1976 budget?

Dr. COOPER. Obviously it will have a bearing on the attempt to implement the 1976 budget if the Congress approves the 1976 request. Specifically, concerning the continuation requirements that the chairman asked, it obviously would have significant impact and, therefore, the answer to your question in a simple word, it is yes. It has significant impact, but looking at it on a longer time scale than just the 1 year, I think our view would be if the management objective could be achieved to adjust to the distribution of funds between continuations and new grant awards that our original strategy would not be greatly put off.

Mr. MICHEL. But if you proposed a rescission in an area of low priority, would your thinking be changed or altered any in the 1976 budget of that very same item in view of the action taken by the Congress?

Dr. COOPER. As I mentioned in my statement, yes, that one of the possibilities would be that lesser priority items might have their continuation costs reduced.

Mr. MICHEL. But in your own thinking, it obviously couldn't change. If you felt it was low priority, you still have that presentation in 1976. Will you still make as hard a case or just concede "Well, what I really thought was really the case isn't so, because you Congressmen are going to see more?"

Dr. COOPER. No; I think you see in our 1976 budget we have already spoken to what we thought were the low priority items.

INFANT MORTALITY RATE

Mr. MICHEL. It is, of course, heartening to note the decrease in mortality rates and that is undoubtedly an indication that we have been successful in some areas in improving health in the country.

You make mention of the significant increases in the past decade or more, and you mention that while the infant mortality rate declined

from 29.2 per thousand, as I recall to 16, in this last year, that our mortality rate still ranks 15th.

Dr. COOPER. Yes, sir.

Mr. MICHEL. I thought it was 13th a few years ago.

Dr. COOPER. No; I think it depends on who is calculating it.

Mr. MICHEL. Would you mind supplying for the record the other 14 countries that have a better mortality rate than ours.

Dr. COOPER. I would be happy to, sir.

Mr. MICHEL. Incidentally, off the top of your head which is the best?

Dr. COOPER. The best is Sweden with a rate of 9.6 per thousand live births.

Mr. FLOOD. Could we read off a few now.

Dr. COOPER. I will read down through 15, Mr. Michel. 9.6 will be best and then they will be worse below that. Sweden, Finland, Norway, Netherlands, Japan, Switzerland, Denmark, France, German Democratic Republic, New Zealand, Australia, Canada, Belgium, United Kingdom, and United States.

Mr. MICHEL. Where do we stand in relation to the number of women who die in childbirth as compared to the rest of the world?

Dr. COOPER. On maternal mortality rates we are 10th and the first again there is Sweden, followed by the Netherlands, Finland, Norway, Denmark, United Kingdom, Belgium, Canada, and Israel. Then the United States.

Mr. MICHEL. I would also be interested in seeing for the record any tables you might have which would compare the U.S. birth rate over the last decade with the birth rates of other countries, if you just simply supply that for the record.

Dr. COOPER. We will supply that.

[The information follows:]

CRUDE BIRTH RATES IN SELECTED COUNTRIES OF LOW MORTALITY, 1950-73

[Rates are live births per 1,000 population]

Year	Austria	Canada	France	Japan	Sweden	United Kingdom	United States
1973	[1] 18.9	15.5	[1] 16.4	[1] 19.4	[1] 13.5	[1] 13.9	[1] 15.0
1972	[1] 20.5	15.9	[1] 16.9	19.4	13.8	[1] 15.0	15.6
1971	21.7	16.8	17.2	19.3	14.1	16.2	17.2
1970	20.6	17.4	16.7	19.0	13.7	16.3	18.3
1969	20.4	17.6	16.7	18.8	13.5	16.7	17.9
1968	20.0	17.5	16.7	18.6	14.3	17.1	17.5
1967	19.4	18.1	17.0	19.5	15.4	17.5	17.8
1966	19.3	19.3	17.6	13.8	15.8	17.9	18.4
1965	19.7	21.4	17.8	18.6	15.9	18.3	19.4
1960-54	21.9	25.2	18.0	17.2	14.5	18.2	22.4
1955-59	22.6	27.8	18.4	18.2	14.5	16.4	24.6
1950-54	23.0	27.7	19.5	23.7	15.5	15.9	24.5

[1] Based on provisional data.

Source: 1969-73, United Nations, "Demographic Yearbook 1973," table 8. 1966-68, United Nations, "Demographic Yearbook 1970," table 13. 1965, United Nations, "Demographic Yearbook 1968," table 13. 1950-64, United Nations, "Demographic Yearbook 1969," table 12.

Mr. MICHEL. I am reminded in our own case—my wife and I have four children. They came in pretty rapid succession a number of years ago, and at that time, we were asked why we quit.

"Did you get tired of having them, or didn't you want any more?" I recall at that particular time, I said, I thought I had read where every fifth birth at that time was Chinese and that is why we quit. That is

why I really wanted to get an updated table of birth rates, et cetera, around the globe.

We are being confronted daily by people who come into our office pleading that the health programs are not really getting enough attention, especially in this year's budget, and enormous increases are called for in order to just maintain our current program.

Yet I was reading a report the other day that cites a study of the health budget from 1969 through 1974 which shows that even after adjusting for inflation, total health outlays increased by more than 40 percent and that almost all major categories made real gains over the period.

Is that a pretty accurate statement, or would you care to expand on that?

Dr. COOPER. No; I think that says it quite specifically.

SKILLED NURSING FACILITES

Mr. MICHEL. The preliminary report on the study of skilled nursing facilities would certainly seem to indicate some real improvements need to be made in this area and then you say in your statement that——

"This survey provides valuable data to those programs in the Department which are responsible for improving standards and practices in long-term care facilities."

On a departmentwide basis what kind of actions do you anticipate to address this problem? What kind of action has already been initiated?

Dr. COOPER. In several areas, as you are probably aware that have received attention in the newspaper, the Department has recommended withholding of funds as a very important sanction for those particular institutions that are not meeting the standards. I think that it has been the absence of that type of activity in the recent past that has subjected the Department to considerable controversy.

Prior to the more recent regulations and activities of the Department, the monitoring of the activities of the nursing home was through State licensure requirements and State monitoring. But in the many cases of both fire hazards and poor standards of practice that have been the subject of both congressional and newspaper investigations, the Department has considerably upgraded its activity, has issued new regulations and standards, and has begun to apply these sanctions to those nursing homes who do not comply.

In addition, however, there are several other specific activities which the Department is undertaking. We are training inspectors. Inspectors have to know what to look for when they monitor nursing homes and the Department has a program to help the States to train inspectors. We are also establishing criteria for guidance for what is acceptable both from the structural standpoint and from the quality-of-care standpoint. Last year the Secretary made this a specific initiative to considerably upgrade the Federal activity in this regard.

RESEARCH PROJECT PRIORITIES

Mr. MICHEL. You anticipate reviewing your grant programs on a project-by-project basis, and you state that some lower priority on-

going projects will receive less funds than originally planned or perhaps will be terminated.

Altogether, and you have told us in your statement what you consider to be priority areas, what type projects would you consider then to be low priority?

Dr. COOPER. By that kind of statement, Mr. Michel, what I mean is those that are low priority on their scientific merit. I would not be presumptious enough to be able to determine what specific scientific areas would be more appropriate to the solution of the health disease problems.

We have a well established and well functioning system in that regard, as you know, but I do think the difference here is that the lower priority in merit can clearly be distinguished.

Mr. MICHEL. Well, I have to get particularly interested in some of these low priority ones, Doctor, because we have been recently inundated with a batch of letters from constituents concerning the apparent waste of Government money on seemingly ridiculous programs, and in some of these stories that have been printed, the more popular items listed were two NIH projects, one entitled "Investigating the German Cockroach," which was funded for several years at a cost of $20,000, another entitled "Research on the Smell of Perspiration From Australian Aborigines" at an estimated cost of $70,000.

Another project to monitor the mental health program was listed as "A Study To Teach Mothers To Play With Their Children."

According to a study done by the General Accounting Office, this project was still active as of last July and has cost the Government about $577,000 since it was first funded in 1968. These are only a few of the many HEW projects and, of course, involve a relatively small amount of money in relation to the entire budget and these particular projects may well have a great deal of merit, depending upon what you are looking for. But it is difficult for me to justify this kind of spending, especially to people back home who expect you to know just where their money is going, and I can't help but wonder sometimes whether their criticism isn't justified.

I have been riding herd on the National Science Foundation and when their bill comes up, we are going to be asking again some very pointed questions, but then when they separate apart and say, "This is out at NIH and that baby is in your subcommittee," I've got to come to you. What answers can you, as a scientist, a skilled professional, a renowned doctor, and one who has been through the hoops, give this committee that we in turn can give those irate citizens back home who keep writing on these projects?

It is a headline in the papers, and with $25,000 or $50,000 for this or that study, we look like a bunch of chumps if we say, "We didn't know they were doing this. We go over these line items very carefully."

"Well, you missed that one and you missed this one."

What do I tell them?

Dr. COOPER. These are looked over very carefully so I think the first thing you can tell them is that these projects are reviewed at several levels.

Mr. SHRIVER. Would you yield to me?

Mr. MICHEL. OK.

Mr. SHRIVER. I brought along just a couple of letters. I got one today:

I know you are only one person, but you can't tell me that everyone else in Congress does not have control of their faculties. With this kind of leadership is it any wonder our country has problems? How much more of this kind of distribution has the Congress been so kind as to pass like gas? If it were me I'd be ashamed to call myself a Member of Congress.

And they list some of the items you are talking about:

$5,000 to learn about Yugoslavian intertidal hermit crabs; $5,000 to tabulate the difference between native American and Indian whistling ducks; and an NIH project—thousands of dollars were spent to prove that a monkey would accept a female dog as a substitute mother!

Every day I get these kinds of letters and they are stimulated, of course, by some commentator to disparage Members of Congress and Congress as an institution. They are asking us these questions. We have nothing to do with it except we provide the research money, but you do have some control over these specific items.

Dr. COOPER. Yes, sir, we do and we take it very seriously. As I was beginning to say, we are very sensitive to the review of the appropriations of the utilization of the funds for research.

The problem is that for a wide variety of informational purposes, because this information is in the public domain, we ask for titles to be put on the specific project. In order to fit a particular form we limit the number of words in the legend that can explain it. Thus it may come out in an abbreviated form that might seem to have very little relevance to any specific scientific or human disease-controlling objective. I think it is this particular identification that is then translated into an interpretation of, not what is in the particular application, but what the word in the English language used to describe the project might mean.

There is really no substitute for that except inquiry and full disclosure and clarification as to what the importance of that particular project is. I think you will find in virtually every one of these cases if we brought to you the actual review process and the rationalization or what the significance is of this work, as is required to be listed on the application, and what its application is to disease, we could make a very fine case to you for its relevance for public support. Beyond that we would also be able to make for you a fine case about the quality of the work itself.

I think that it is unfortunate that, the language interpretation being what it is and the identification being what it is, we have limitations in giving research projects titles. I would stay with the current system, with all of the criticism, rather than to go to something like a number identification because I think it is important that the public understand what it is we are doing. If we are not making clear what the purpose and the yield of science is, it is our job, helped by you, to try to get that word out in a better way. But it is appropriate. I know of no other way than to ask further questions when the actual language itself becomes an inappropriate or inadequate explanation for the expenditure of funds. But I can assure you that, both at the administrative level and at the review level, all of these seemingly bizzare-titled things of what appears to be trivia are extremely important.

I could take the crab, for example. Some of the finest work on the nervous system and understanding nervous diseases, and for what we are doing today, comes from working on crabs. It doesn't come through in that title, but if we had the time to say it then we could do that.

Mr. MICHEL. For this record, would you supply a few of those examples, because I certainly don't want to in any way tend to inhibit the scientific community that knows far more than I do as a mere layman.

Dr. COOPER. Yes.

[The information follows:]

Examples of important research which might have appeared absurd to a lay person familiar only with the title of the research.

Dr. Joshua Lederberg was awarded the Nobel Prize a number of years ago for the discovery of the fact that certain bacteria and particularly *E.coli* underwent sexual congress with transfer of genetic material from one microorganism to another. I suggest that "the occurrence of sexual intercourse among bacteria" would have been regarded by many as a frivolous and unimportant area of research. However, quite the contrary has proven to be the case, as was early detected by the Nobel Prize commission. The genetic information which is transferred from one bacterium to another during such intercourse is contained in segments of DNA called plasmids, and it is apparently due to plasmid transfer that such characteristics as antibiotic resistance can rapidly be spread among a population of bacteria. The clever experimenter taking advantage of this kind of event is today able to introduce novel genetic information into a microorganism and in this way alter its function to the advantage of his science. Lederberg's discovery is one of the very important single events which have contributed to the rapid advance in our understanding of genetics.

Historically, the great forward thrust in genetics about 50 years ago stemmed from the observation that the fruit fly, *Drosophila melanogaster*, had only four chromosomes in its somatic cells, and curiously that these chromosomes in the cell of its salivary gland were exceptionally large and readily visualized. A title such as "A study of the chromosomal transmission of genetic information in *Drosophila melanogaster*" might well have been ridiculed by contemporary lay persons. However, the work initiated in this field by Thomas Hunt Morgan and his collaborators laid the groundwork for the all important technique of chromosomol mapping of genetic information, and to the concept that the genes were displayed in a linear array along the axis of the chromosome.

The sea urchin is a simple marine form which has served as an extraordinary useful provider of ova and sperm. It is found in large numbers in our tidal waters and, because of the ease of securing abundant material for research purposes, has served as an extremely important model for the study of the primary events in fertilization and in the process of artificial parthenogenesis, which is fertilization in the absence of sperm. It happens that this process is relatively constant throughout many animal forms, and that information secured from sea urchin eggs is directly applicable to other forms of life, including mammals. The procurement of ripe ova from the mammal is an extraordinarily difficult feat and has only rarely been accomplished. On the other hand, a very large number of important studies have been conducted on see urchin materials.

The squid is a relatively primitive marine form which has one remarkably attractive feature to the biologist. Its nervous system which is quite simple in structure contains a truly giant axon. The axon is the linear conducting element of nerve impulses, and the presence of a giant axon sufficiently large that one can relatively readily insert a small pipette inside the axon has been a great boon to the development of neurophysiology. This preparation has permitted the simultaneous measurement of concentration of chemical substances inside and outside the axon, and also measurements of the electrical potential differences across the axon sheath. From such information we have reconstructed the nature of the mechanism whereby nerve impulses are transmitted along the axon, a process which is confidently believed to occur in substantially unaltered form in all nervous tissues. Without the squid axon, it is altogether likely that our understanding of this process would have been very much delayed. For the past 50 or more years, the attractiveness of certain marine biology stations for neurophysiologists has rested largely upon the availability of the squid for such studies. It is possible that a title such as "The change in electromotive force across the membrane of the giant axon of the squid" would not seem to be as serious a venture to the layman as it is indeed to the medical biologist.

Ridicule is, of course, a common vehicle and certainly has its uses. It is, I believe, a characteristic of scientific education that, as one develops, one becomes less and less willing to ridicule the subject of another scientist's investigation.

We have long since learned that the wise scientist reviews many different preparations before selecting the one which is best suited to supply the answer to the question before him. Sometimes the best preparation is man himself. Sometimes it is a microorganism; sometimes it is some other form of living tissue. The more we learn about the diverse forms of life, the more frequently we find a preparation which is better suited to our purpose than ones which have been deemed conventional in the past. Possibly the first time that a biologist extracted a biological generalization from observations on the mouse or the rat, he was also held to ridicule. However, today these common laboratory animals are widely recognized as appropriate subjects for biomedical research. It is, in general, a hazardous policy to form judgments based exclusively upon the titles of projects. A study of the project itself and an understanding of the motivation of the investigator will often reveal the reasons for the selection of the method of study that has been made.

Mr. MICHEL. I agree with you that it would be deceiving if we had them numbered 1, 3, 5, 10, whatever number, and then we really don't know what we are doing.

Dr. COOPER. I think that would be totally inappropriate.

Mr. MICHEL. But by the same token, if the end objective some way could be the title. Maybe knowing what makes the odor of perspiration from an Australian aborigine might be good for Mitchum and Arrid and the private industry, and we are subsidizing their research. I don't know. That is the first thing that comes to mind. Maybe it is something more than that, and if so, if there is a good reason, I would like to know about it.

Dr. COOPER. We also point out how information can be gotten. There is a repository of summaries of what the actual contents of the activities are that are available to the public and we should make it clear that when the press or the media go to report this sort of thing, there is a relatively accessible simplified summary of what is going on in a particular activity that is available to the public; and I think that we would do that.

Now, that is not to say one thing; and I want to be absolutely clear, Mr. Michel, and that is sometimes we do make mistakes. We will guess wrong. But we could just as well guess wrong on a project that would be entitled "A New Treatment for Heart Disease" as "The Crab in Yugoslavia." So we are not infallible. We make the best judgment we can on the basis of scientific merit.

Mr. MICHEL. If no other good comes from it, perhaps just the exchange that we have had here could be used to impress upon the minds of those out there doing the work, that we have a real problem justifying that, and we have a little bit more to talk about than what we have had by these mere titles.

It is pretty darn tragic in this country when the criticism we get narrows down to some of these rinky-dink items like this. We are talking about a multibillion-dollar budget here and the things that get all the visibility are the nickel-dime stuff, but that is life and that is what makes stories, apparently, and we have to cope with it.

Mr. SMITH. Would the gentleman yield?

Mr. MICHEL. Yes.

Mr. SMITH. I think a lot of this comes from some fellow over here in Virginia who calls himself the National Taxpayers Union, who put out a release and a lot of these titles he used were not the correct titles at all. They were phony titles to start with. And there has been a study of every one of the things that he listed and you might want to include at this point the study which is already done on all of those.

[The study follows:]

Summary of Information Obtained Regarding a March 1974 Article on Federal Expenditures

(By U.S. General Accounting Office, Financial and General Management Studies Division, Congressional Information Services Group)

SUMMARY

In March 1974, an article by James D. Davidson, executive director of the National Taxpayers Union, appeared in newspapers throughout the country, discussing a number of seemingly wasteful government expenditures. GAO was requested to review the various projects mentioned. Our investigation consisted primarily of locating the sources of the projects and verifying the expenditures through telephone calls and interviews. No adults were performed.

Some of the research projects mentioned by Mr. Davidson are over 10 years old which made them difficult or impossible to identify. Several discussions were held with the author as to his sources. In some cases, such as the "$2 million to purchase a luxury yacht" for Marshal Tito, Mr. Davidson could not cite his sources and we were unable to locate them within the Federal agencies.

In other instances, GAO had previously performed audits relating to certain of the projects mentioned, and these are identified in the discussions and attached.

Mr. Davidson's characterizations are used in the titles that follow:

DEPARTMENT OF AGRICULTURE

The two resarch projects listed below were conducted by the USDA several years ago using special foreign currencies. Public Law 480 provides for the use of U.S.-owned foreign currencies which cannot be converted into dollars, but which may be used for scientific research beneficial to U.S. agriculture and the American consumer. (For a further explantion of the use of "excess" foreign currencies, see the Smithsonian Institution section.)

1. Odor-Measuring Machine Purchased for the Turks, $28,361

The project is properly titled, "Development of an odor-measuring instrument for use in inspection and grading of foods." It was conducted over a 3-year period at Robert College Research Center in Turkey and completed in 1965. According to the USDA, the project investigated the feasibility of using odor-measuring electronic devices to help in determining the quality of fresh and stored food products as an aid in grading and inspection to insure safe and high quality foods. The project developed many standardized, instrumental measurements of odors associated with food products. The USDA official stated that the machine was developed far more for its use in the United States than for its possible use in Turkey and was not a case of "the odor-measuring machine we purchased for the Turks." The total cost was $29,361. (Sources: Letter from USDA official, Agricultural Research Service staff, May 1, 1974, and telephone interview.)

2. Study of the Blood Groups of Polish Zlotnika Pigs, $20,000

This 5-year study was conducted at the Agricultural College in Poznan, Poland, and completed in 1967. The total amount spent was $20,556. The research investigated red blood cells and serum antigens in this new racial group of swine. According to a USDA official, the purpose was to determine blood-group relationships among major swine races of the world as an aid to swine breed improvement as well as for genetic studies of the nature of immunity to swine diseases. The results were applicable to swine breeding problems in the United States as well as in Poland. (Sources: Letter from USDA official, Agricultural Research Service staff, May 1, 1974, and telephone interview.)

3. Payment to Queen Elizabeth for Not Planting Cotton in Mississippi, $68,000

The 1972 Agriculture Stabilization and Conservation Service (ASCS) and Great Plains program payments include a subsidy of $67,795 to Delta & Pine Land Co. Delta & Pine, according to a USDA official, is a wholly owned subsidiary of Courtald's, Ltd., a British company. The Royal Family is a major stockholder in Courtald's. (Sources: USDA official, telephone interview; Congressional Record, May 3, 1973, p. E2842.)

4. Subsidy Payment to Ford Motor Co. and Libby McNeil, $14,000 and $19,000

The 1972 ASCS and Great Plains program payments in excess of $20,000 are listed in the May 3, 1973, Congressional Record, page E2842. No listing is made,

however, for those payments under $20,000. This problem, coupled with the absence of data on the county and State in which the farm is located, combine to make it difficult to verify the accuracy of either item.

DEPARTMENT OF COMMERCE NATIONAL BUREAU OF STANDARDS

5. Interdepartmental Screw Thread Committee, $250,000

Both the purpose of the committee and its cost have been inaccurately reported. Fiscal year 1973 expenses, according to Arthur Strang, chairman of the committee, amounted to $3,600, not the alleged yearly cost of $250,000. The Screw Thread Committee is not funded through a general appropriation request; instead, the committee's operation is handled as a side-issue of the National Bureau of Standards.

The interagency committee was formed to coordinate the efforts of the major Federal agencies concerned with the design or procurement of screw thread fasteners. This committee is composed of officials from various agencies and the private sector who generally devote only a small part of their time to the activities of the committee. (Sources: Arthur Strang, National Bureau of Standards, Chairman, Interdepartmental Screw Thread committee, telephone interview, and letter from J. E. Skillington, Chief, Budget Division, National Bureau of Standards, to David Nathan, Director, Office of Budget and Program Analysis, Department of Commerce.)

DEPARTMENT OF DEFENSE

6. Alaskan Chateau, $100,000

The Alaskan Chateau is a facility for the use of distinguished and high-ranking visitors including those on aircraft making fuel stops at Elmendorf Air Force Base, Anchorage, Alaska. As of May 1972, 22 military personnel were operating the Chateau and Health Club at an annual cost of $170,000.

As a result of the GAO inquiry into this matter, the Air Force decided on September 8, 1972, to reduce the authorization of appropriated manpower to the Chateau to six persons—a number considered to be consistent with the necessary operations of the Chateau. (Source: GAO letter report to Senator William Proxmire, October 25, 1972.)

7. Outfitting jets, $600,000

A GAO report indicates that $670,000 was spent on refurnishing one C–135 aircraft. The specially designed jet contained a galley with a range, freezer, trash compactor, two divans, sink and cabinet, three bathrooms and carpeting. Payment for the renovations came from two sources: P–1000 aircraft modification funds and operation and maintenance allotment. P–1000 funds are justified before Congress as necessary to correct unforeseen safety-of-flight modifications. Operation and maintenance funds normally go for routine servicing of the aircraft.

The GAO concluded its investigation by stating that in view of fund shortages, the expenditures for this project were not the most prudent use of available funds. Consequently, regulations now require that all modifications to command support aircraft must be approved and authorized by Air Force Headquarters. (Source: GAO letter report to Senator William Proxmire, August 21, 1973.)

8. Air Force missile silo cover, $1 million

In the early 1960's when the first Minuteman I missiles were being deployed, a project was undertaken to develop a tent to protect missile alinement teams. These teams, operating outside the missile silos, alined each missile guidance set using geodetic survey techniques and equipment such as the theodolite, which is a very precise surveying instrument. The alinement procedure was required frequently, at all hours of the day and throughout the year. Under ideal conditions, it was difficult to obtain the necessary alinement accuracy with the theodolite—it was extremely difficult with strong winds or cold winter weather. The intended purpose of the tent was to shelter the personnel while alining the missile guidance set.

Before development of the tent was complete the missile alinement procedures were changed, significantly decreasing the necessity to utilize the theodolite in the exposed position outside the silo. Consequently, the project was stopped on March 19, 1964, at a total cost of $13,057. At the time the project was stopped there has been at least one occasion in which a prototype tent blew away during

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a test with 60 mi/h winds. The contractor for this project was the Autonetics Division of North American Aviation. (Source: Letter from Col. Thomas G. McConnell, Chief, Congressional Investigations Division, Office of Legislative Liaison, USAF, to Senator William Brock, July 31, 1973.)

9. Pentagon frisbe study, $375,000

The objective of the self-suspended flare study was to develop an improved aircraft-launched flare for naval applications which would be safe, consumable, cheap, and reliable. The study, initially funded in fiscal year 1968, determined the concept feasible, but two major problems were encountered. The flare as developed had a burn time of less than 1 minute and launcher complexity required added development and additional aircraft maintenance. On the basis of the results obtained, it was decided that the actual project should not be initiated. Accordingly, in the fall of 1970, the entire program was terminated.

Two firms, Honeywell and Denver Research Institute, were awarded contracts of $79,997 and $108,902, respectively. In-house costs totaled $186,931. Total expenditures for the project came to $375,023. (Source: Letter from Commander, Naval Air Systems Command to the Chief of Legislative Affairs, Department of the Navy, November 19, 1973.)

EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF ECONOMIC OPPORTUNITY

10. Grant to the city of Los Angeles to extend travelers' aid to migrants lost on the freeway, $203,979

A grant of $243,740 was awarded to the Economic and Youth Opportunities Agency of Greater Los Angeles (now the Greater Los Angeles Community Action Agency) to be applied during a 2-year period from 1965 to 1967. The Federal money was, in turn, given to the Travelers' Aid Society in Los Angeles, a social service agency. The primary purpose of the grant was to aid the great influx of people moving to Los Angeles. Approximately $10,000 was allocated for the use on operating a main office of Traveler's Aid and a smaller office known as the and others who might need help. The vast majority of the OEO funds was spent on operating a main office of Traveler's Aid and a smaller office known as the newcomers center in south central Los Angeles.

In late 1967, Traveler's Aid petitioned for and received an additional 60 days in which to close down the records and activities operating on the basis of the grant, to report out the results of the project, etc. No further funding to the Traveler's Aid Society has been supplied since February 28, 1968. (Sources: City of Los Angeles official from their Washington, D.C., office and a spokesman for the Traveler's Aid Society in Los Angeles, both telephone interviews.)

11. Condom stamp program, $23 per item

Population Services International was awarded an initial grant of $47,000 by OEO to discover innovative means of providing needed sex and contraceptive information to American youth. Funds were allocated to the development of educational materials for teenage males, to testing distribution methods for these materials, to teaching young men how to avoid unwanted pregnancy and venereal disease, and finally to offering the option to purchase subsidized supplies in a nonthreatening way. (Source: Letter from Philip D. Harvey, Director of PSI, to the Washington Post in response to an editorial by Nicholas Von Hoffman entitled "An $18 Value, Yours With This Coupon . . ." (printed in the Post on July 11, 1973, p. C5) (letter response dated July 13, 1973).

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
FOOD AND DRUG ADMINISTRATION

12. Board of Tea Tasters, $117,250

According to an official in the budget office of the Food and Drug Administration, DHEW, the board meets twice a year—once to set standards on tea importation and a second time to review and decide on all appeals arising from disputes over regulatory actions. The total cost of the Board's activities is roughly $700 per year. The figure of $117,250, for fiscal year 1974, approximately the amount originally requested by the FDA, includes all of the costs of tea importation regulation. This includes, for example, chemists' salaries and expenses, necessary analysis costs and compliance costs. However, due to an amendment to the final appropriation bill, expenditures on tea importation cannot exceed revenue. This has restricted all tea regulation activities to approximately $57,500 which is

equal to the total amount of earnings gained from fees charged. (Source: FDA budget office official, telephone interview.)

13. Study to figure out why children fall off tricycles, $19,300

About 4 years ago, the Bureau of Product Safety in the FDA conducted a study of children's hazards. This study included the hazard of children operating wheeled vehicles. The study's objective was to determine what safety standards were needed for off-the-road vehicles. Approximately two-thirds of the study concentrated on the stability of minibikes and trail bikes and one-third of the study dealt with three-wheeled vehicles, including tricycles. Aspects of this study included the need for chain guards, safety helmets, etc., as current (at the time) regulations covered only vehicles operated on public roads. According to a FDA official, the cost was about $20,000. (Source: Discussion with product safety personnel.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NATIONAL INSTITUTES OF HEALTH

14. Study of the German cockroach, $20,000

Since the cockroach is one of the most resistant insects to normal methods of control, it represents a useful experimental tool for the development or testing of new methods for the reduction of insects. An NIH official identified two terminated projects utilizing the German cockroach for this purpose. The projects were funded for several years, beginning in 1965, at a cost of $20,000 per year. (Source: NIH official, telephone interview.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NATIONAL INSTITUTES OF HEALTH

15. Research on the smell of perspiration from Australian Aborigines, $70,000

This is one of 16 subprojects concerned with zoophysiology in Alaska. The purpose of the subproject was to learn about the adaptation of man to his environment and involved a comparison of the Alaskan Eskimo with the Australian Aborigine and their stress reactions to climate. The project has not been funded since 1971. It can be identified as NIH Research Grant No. 5TO–EC00031. (Source: NIH official, telephone interview.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NATIONAL INSTITUTE OF MENTAL HEALTH

16. Study to teach mothers to play with their children, $159,000

This study was first funded in 1968 with a $149,000 grant to Dr. Ira Gordon at the University of Florida's Institute of Development of Human Resources. The overall title of the study is, "Home Learning Center Approach to Early Stimulation." NIMH describes the purpose of the project as follows, "This project will study the effectiveness and practicability of a home center technique to provide cognitive language and personality development stimulation for the child and to increase the competence of the mothers through a program of parent education conducted by nonprofessional visits to the home and small group learning centers." This project is still active with total direct and indirect costs amounting to $576,969. (Source: Grants officer, National Institute of Mental Health, telephone interview.)

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

17. Low Cost Housing for Low-Income Residents in Washington, D.C., $76,000 Each

In January 1969, the Redevelopment Land Agency (RLA) received a HUD grant of $29.7 million to carry out urban renewal activities during the first action year of the neighborhood development program in the Shaw School and downtown urban renewal areas. RLA acquired the sites for $1,497,660. This amounts to about $27,700 for each of the 54 townhouses to be constructed on the sites. The GAO examined 35 other commercial property acquisitions to determine whether the amounts paid by RLA for the sites were representative of the amounts paid for other urban renewal properties, but could not arrive at a realistic comparison.

RLA subsequently sold the sites to a nonprofit developer, D.C. Frontiers, Inc., for $56,700 or at a cost per unit of approximately $1,050. The large difference

between the price paid and the prices received resulted because RLA had acquired the land while it was zoned as commercial property, whereas, in compliance with the HUD-approved general land-use plan for the Shaw area, the land was rezoned as residential property before it was sold to the developer. (Sources: National Capital Housing Authority officials, telphone interview and "Prices Paid for Property Acquired in Urban Renewal Programs in the District of Columbia," report of the Comptroller General, April 3, 1973, B–118754.)

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

18. Design and Testing of a Zero-Gravity Toilet, $310,000

Funding amounts for the development of the zero-gravity toilet for the space program did not appear in the general appropriations hearings of NASA, but were, according to one NASA official, "buried in the program requests."

The information as it originally appeared in Playboy (April 1973) and subsequently publicized by James Davidson states that $80,000 was expended for the design of a zero-gravity bathroom for the Space Shuttle and an additional $230,000 for "environmental testing." The figures are confusing in that NASA actually devised and funded two types of systems. The first is a lab model. It was followed by an engineering prototype. Hamilton Standard was awarded a $73,000 contract to design and fabricate a lab model of a zero-gravity toilet. An additional $13,000 was spent testing one piece in zero-gravity airplane flights. This project was terminated in November 1972, whereupon NASA and Hamilton embarked on the second phase of the operation. In December 1972, Hamilton received an allocation of $225,000 to design, fabricate, and ground test a complete system. Ground tests were completed in February 1974. Air testing followed and cost an additional $40,000.

Total costs to date are approximately $351,000. At the time the Playboy article was released, $86,000 had been expended for the lab model and $225,000 for the engineering prototype.

Additional information can be found in an August 16, 1972, NASA news release entitled, "Bathroom-Commode Design for Space Shuttle Passengers," release No. 72–163. (Source: NASA official, Life-Sciences Division, telephone interview.)

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

19. Payment to the Author of "Lighthouse" $5,000

According to a Foundation official, Aram Saroyan (son of William Saroyan) authored the poem "Lighght." The poem, only seven letters long, is considered a literary illustration of refracted light. He was awarded $500 when it was selected for the American Literary Anthology. The Anthology project was given Federal assistance for a period of 3 years in the hope that the editors, George Plimpton and Peter Ardery, could secure private funding once Federal funding expired. They failed to do so and the project was discontinued in 1970. The payment to Aram Saroyan was made sometime in 1969 (fiscal year 1970). (Source: National Foundation official, Arts Division, telephone interview.)

20. History of Comic Books, $71,000

No information was readily available on a history of comic books. However, Foundation officials were aware of a study conducted into the history of comic strips.

A grant of $8,700 was awarded by the Foundation to the University of California at Santa Barbara for Prof. David Kunzle to study the history of 19th century European comic strips. The study, entitled "The History of the Comic Strip, Volume II: the 19th Century," focused on the social and political style of the comic strips which was much more prevalent then than now. (Source: Foundation official, Art and Social History Division, telephone interview.)

21. Dictionary of Witchcraft, "A Few Grand"

In response to a general inquiry on a "Dictionary of Witchcraft," an Endowment official reported that a grant had been awarded to the University of California at Los Angeles to support the gathering of information for the reference book: American Popular Beliefs and Superstitions, a standard work for use in the fields of linguistics, mythology, and folklore. The sum of $24,134 was awarded on February 15, 1974. The project had been supported in previous years, according to the spokesman, by a grant of $21,995.

It should be noted that this information was provided in response to a general inquiry based on the Davidson article only. It may well be that the above findings refer to something entirely different from that cited by Mr. Davidson. (Source: National Endowment Public Information Office official, telephone interview.)

NATIONAL SCIENCE FOUNDATION

Two studies referenced in the article, the Central American toad and the population biology of Indo-Australian ants, were funded in 1963 and 1964 and came under the overall heading in the foundation's justifications of "scientific research project support." An official of NSF pointed out that all titles of the foundation's research projects are listed in their annual report, in a separate volume on grants and contracts awarded. Also, almost daily, a listing of awards is sent to every Member of Congress, as they are made.

According to the Foundation, "research project proposals are considered primarily on the basis of scientific merit. Scientific merit is assessed according to the promise of significant scientific results, the possible scientific impact, the probable opening of a new field, the educational byproducts, and potential application."

22. Study of the Mating Calls of Central American Toads, $20,324

The "Invesitgation of Mating Calls and Paratoid Gland Secretions of the Central American Toad" was conducted under a grant for $21,200 awarded in 1963 for 2 years. The study, in addition to adding to scientific knowledge of evolutionary relationships, provided data on the chemical properties of toad venoms in connection with heart stimulation studies in humans. (Source: National Science Foundation official, telephone interview.)

23. Study of Indo-Australian Ants, $70,000

A study of Indo-Australian ants was conducted at Harvard University beginning in 1964. The study lasted 36 months with costs of approximately $70,000. According to an NSF official, because this project was terminated several years ago, they were not readily able to further describe the purpose of the research. (Source: NSF officials, telephone interview.)

SMITHSONIAN INSTITUTION

The Smithsonian projects listed below are all part of the special foreign currency program, a brief description of which follows.

Under provisions of Public Law 480, the U.S. Government sells surplus agricultural commodities and other materials to foreign nations and foreign currencies are accepted in payment. The local currencies received are used for economic development loans to the purchasing nations and for "U.S. users" with accounts established in the purchasing nation's central bank. Agencies may then purchase foreign currencies from these accounts for programs supported by dollar appropriations. The Treasury publishes a list of so-called excess currency countries whose currencies are then made available to Washington agencies receiving a special foreign currency program appropriation. This is not considered equivalent to a dollar appropriation since no dollars, only "excess" foreign currencies are available to agencies receiving it. U.S. expenditures include construction and operation of embassies and information centers, the Fulbright exchanges, loans to American businesses, and collaborative research and education programs. The Smithsonian's use of these funds stems from the State Department's request in 1966 that the Institution take over the Department's program of foreign currency grants to U.S. archeological institutions. Subsequently, the national grants program was extended to other areas of Smithsonian competence.

Congress does not review individual projects under the special foreign currency program but rather an illustrative list of projects is presented at the time of the agency's justification hearings. All of this material is made a part of the record of the appropriations hearings by the Subcommittee on Interior and Related Agencies, House Committee on Appropriations.

24. Study of Lizards in Yugoslavia, $15,000

Estimated Federal expenditures for fiscal year 1974 are $15,000. This study aims to show how a more vigorous and adaptable species of lizards can gradually colonize and displace a less hardy species. (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency

program) list of projects, submitted as a supplement to the fiscal year 1974 budget, February 1973, p. 54.)

25. Collection of Rare Moss in Burma, $5,000

The Missouri Botanical Garden and Rangoon University propose to collect the mosses of Burma to fill an important gap in the collections in St. Louis which are the best for systematic studies of the moss flora of the world. To date, this project has not been funded. (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency program) list of projects, submitted as a supplement to the fiscal year 1974 budget, February 1973, p. 32.)

26. Study of Wild Boars in Pakistan, $35,000

The wild boar causes crop damage in Pakistan alone estimated at $35 million annually. Its control has been of concern to the Pakistani Government, as it is to the other countries stretching from India to Europe. In Muslim countries, the boar is considered, like the pig, an unclean animal and its numbers are not, therefore, controled through regular cropping. The study provides basic biological information, and information on the behavior and feeding habits of the boar upon which a program of control can be based. Estimated Federal funding for fiscal year 1974 is $35,000. (Source: Smithsonian Institution (special foreign currency program) list of projects, excerpts, submitted as supplements to the fiscal year 1974 and 1975 budgets, p. 1.)

27. Study of the Bisexual Behavior of the Polish Frog, $6,000

Fiscal year 1974 estimated expenditures are $6,000. A study of the "bisexual behavior" of frogs is an inaccurate characterization of this project. More properly, this study attempts to properly classify *Rara esculenta*, which is either a hybrid or a separate species of frog, by enzyme and protein analysis. In addition, the project will provide the opportunity for Polish and American scientists to share the latest techniques in species identification. (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency program) list of projects, submitted as a supplement to the fiscal year 1974 budget, February 1973, p. 54.)

28. Study of the Impact of Rural Road Construction in Poland, $85,000

Fiscal year 1974 expenditures are estimated at $85,000. The basic question posed is: What happens when a road is built into a village or rural area previously isolated from the outside world. What happens to the people, their culture, their families, patterns of trade, immigration and emigration, etc? (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency program) list of projects, submitted as a supplement to the fiscal year 1974 budget. February 1973, p. 29.)

29. Study of the Impact of Rural Road Construction in Yugoslavia

This project is similar to the one in Poland but has not yet been funded, according to a Smithsonian official. Refer to the prior project for a description. (Source: Smithsonian Institution (special foreign currency program) list of projects, excerpts, submitted as a supplement to the fiscal year 1974 and 1975 budgets, p. 2.)

30. Study of Intertidal Hermit Crabs in Yugoslavia, $5,000

One of the insights of modern biology has been that species often compete for the same food and dwelling space. The species which excels at this sort of competition is likely to displace the species which is less efficient in this respect; this is one of the principal mechanisms of evolution. The study aims to document a particular instance of this competition between species in nature, in this case, two species of hermit crabs in Yugoslav waters. The study has not only theoretical implications for a better understanding of organic evolution, but will document the biology and distribution of the crabs being studied. This project has not yet been funded, according to a Smithsonian official. (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency programs) list of projects, submitted as a supplement to the fiscal year 1974 budget, February 1973, p. 32, and Smithsonian Institution (special foreign currency program) list of projects, excerpts, submitted as supplements to the fiscal year 1974 and 1975 budgets, p. 1.)

31. Study of American and Indian Whistling Ducks, $5,000

Estimated Federal expenditures for fiscal year 1974 are $5,000. In the face of habitat changes caused by human encroachment some species of wildlife are able to adapt successfully while others have become extinct. Studies conducted by Texas Tech on the life cycle of whistling ducks in this country, as compared to anatomically nearly identical ducks in India, suggest that the Indian ducks have developed the ability to adapt to a more varied environment. Discovery of the reasons why a nearly identical bird species has different abilities to adapt may suggest ways in which an endangered species can be introduced, and preserved, in a different environment. (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency program) list of projects, submitted as a supplement to the fiscal year 1974 budget, February 1973, p. 46.)

32. Study of the Biological Rhythms of Catfish in India, $25,000

Experimental work was planned on daily and annual rhythms in the life of catfish with the purpose of learning whether or not catfish could multiply more rapidly and thus produce more high protein food for India. Material supplied to the House Appropriations Committee by the Smithsonian Institution states that this project will not be funded (Source: Smithsonian Institution Museum Programs, scientific and cultural research (special foreign currency program) list of projects, excerpts, submitted as a supplement to the fiscal year 1974 and 1975 budgets, p. 4.)

DEPARTMENT OF STATE

33. Limousine for Brezhnev

According to a State Department official, the car (not a limousine) was given to Brezhnev by Ford Motor Co. at no cost to the American taxpayer.

U.S. HOUSE OF REPRESENTATIVES

34. Furnishings for House Speaker Carl Albert's Office, $161,650

The expenditures listed in the article are not for the Speaker's Office, but for the Speaker's lobby which consists of reception areas in the Capitol building for use by all Members of Congress.

On September 20, 1972, in hearings of the House Committee on Appropriations, Subcommittee on Legislative Branch Appropriations, the chairman, Representative Casey, asked if the furnishings for the Speaker's lobby were in the fiscal year 1972 appropriations, under the appropriation for furniture and furnishings for the House side of the Capitol. He was told that the subcommittee is provided a general breakdown as to the proposed use of the lump sum. The only reference to the refurbishing of the Speaker's lobby is contained in a portion of the 1972 justification material under an item called, "Purchase Of Drapery Material, Cleaning." The line item in the appropriations bill is termed, "Furniture and Equipment" with no further breakdown. (Source: *Supplemental Appropriation Bill, 1973*, hearings before Subcommittees of the Committee on Appropriations, House of Representatives, 92d Cong., 2d Sess., Sept. 20, 1972.)

SOURCE UNIDENTIFIED

35. Purchase of a Yacht for Yugoslavia's President Tito, $2 million

James Davidson, author of the article, was unable to identify the source of his information, believing to have read it in a newspaper some time back.

The State Department has no knowledge of such an expenditure. Further, they doubted if State, because of its limited budget, would ever allow such a large sum to be spent. The Agency for International Development (AID) has a commodity code system for Federal expenditures involving foreign countries. One official checked back as far as 1967 and found nothing listed under the "vessels and related equipment" category for Yugoslavia. An examination of technical assistance and capital assistance grants dating back as far as 1953 found no indication of any moneys being spent on a yacht.

Mr. MICHEL. I used to ask for them and I got reluctant to as one of our colleagues from Iowa, who is not in the Congress any more, was just having a field day down on the floor, and I was having a time defending my own record which I made in the first instance just to be a little better educated and informed.

Termination of Comprehensive Grants to States

Dr. Cooper, you mention on page 6 this $90 million reduction in the budget resulting from the application of the policy you are talking about, the proposed termination of the comprehensive health formula grant program. You mention that the legislative authority terminated June 30, 1974, and it, of course, is being carried forward as a result of the continuing resolution then in funds requested in 1976.

Now, in the transition with respect, for example, to the regional medical program and some of the others, in the supplemental you asked for, as I recall, $12 million and we added $38 million bringing it up to $50 million, and that, too, is a program that has expired but is being carried forward and then is supposed to be changed by the new authorizing legislation.

What is that going to do over here if we get about to thinking, "Well, let us pile on some more here, and notwithstanding the fact that the authorization ended June 30 last year, let us put some more money in here?" What are you going to do with it?

Dr. Cooper. The so-called Health Services bill or the Health Revenue Sharing bill, S. 66 in the Senate and I think it is H.R. 4925 in the House, has not yet been acted upon. We would expect by the summer that the Congress would decide whether this activity should be continued or not, and I think our own advice on it, whether there is authority or not, would be to discontinue the budget item for that particular activity.

We think the planning activities and the possibilities for some of the activities in the National Health Planning and Resource Development Act will be very important ones and in some cases are activities that were related to some of the utilization of that $90 million, but I doubt very seriously whether it was in any significant amount an activity that would be replaced by the new health planning legislation.

Health Manpower Training

Mr. Michel. How about where you speak of the 1976 budget reflecting a continuing effort to change the role of the Federal Government in funding the training of health professions and medical research personel?

"The health manpower authorizing legislation expired in June of 1974, and we are requesting $339 million in 1976 to cover the requirements for the legislation proposed. * * *"

Is that up here?

Dr. Cooper. The manpower bill has been heard in the Interstate Commerce Committee in the House but it has not yet been heard by the appropriate committee in the Senate. Again we expect that during the spring a decision will be made by the Congress on manpower legislation. There are still different versions of legislation proposed. Our calculations of what is appropriate are based on the administration's proposal and what we think would be an appropriate expenditure for the national objectives that are seen for the health manpower area.

Mr. Michel. I will assume then that is going, I hope, to dovetail if we enact that legislation pretty much like you wish.

Dr. Cooper. Yes.

Mr. MICHEL. Mr. Chairman, I have a number of questions, too, and if we go around the horn I might like to do them personally rather than submitting them, depending upon the time.

Mr. FLOOD. Mr. Natcher.

CANCER RESEARCH

Mr. NATCHER. Dr. Cooper, I want to thank you for the statement that you have made to our committee today and as one member of the committee you have heard me say before I think you are doing a good job.

Dr. COOPER. Thank you, sir.

Mr. NATCHER. You have a difficult assignment and the questions that I have propounded here pertain to certain matters concerning cancer research.

From time to time we read articles in the paper and in different magazines and so forth concerning cancer research generally. Some of our people in the medical profession are a little disturbed about the rate at which we have our cancer research under way, as to speed and so forth.

You have heard these questions propounded from time to time, Dr. Cooper?

Dr. COOPER. Yes, sir.

Mr. NATCHER. And I know that you probably read the article that is based on certain statements made by a Dr. James Watson.

Dr. COOPER. Yes, sir.

Mr. NATCHER. You are acquainted with this article?

Dr. COOPER. Yes, sir.

Mr. NATCHER. As far as cancer research is concerned generally, I presume you have probably answered these statements, have you, in letters and otherwise, Dr. Cooper?

Dr. COOPER. Yes, sir, I have.

Mr. NATCHER. Of course you made no promises to the American people or any of your associates that cancer will be solved tomorrow. It is a right difficult matter, but I am glad to hear that this has been called to your attention.

Dr. COOPER. Yes; we are very much aware of that concern, Mr. Natcher.

The way I usually approach the answer to that particular question is to try to have folks recognize that there really are three bases on which decisions are made for the allocation of funds.

One is on the size of the problem. The second is on the public's preception of the importance of the problem. We are a public agency and their representatives here in Congress have a responsibility to make that priority weighing. And the third is a very important one which is more in our bailiwick and that is on the scientific opportunity that is available.

I think it is on these three foundations one can make a judgment as to what would be the best allocation for the resources available to respond to those three things.

Now, there are different scientists who feel that a different allocation should take place, but since these are public funds I think we have to take into consideration all three.

As a scientist, and coming from the heart field, I might have a little greater affection for putting more of that cancer money in the heart field, or since diabetes is a very important problem I might feel that a greater percentage of it in my own personal opinion might go better in diabetes; and I might say for the record, that indeed in all these areas there is great scientific opportunity at the present, but the actual decision of allocation is very much a public policy decision and not only a distorted scientific opinion.

Mr. NATCHER. Dr. Cooper, we have in past years asked for the record here how much the Government spends a year on research on smoking and health and on what projects that money is spent. Not education or behavioral study—but actual clinical and experimental research.

We know that a great deal of what is expended is under the carcinogenesis program of the Cancer Institute. But there's research involved, too, we know, in other components of NIH—in the Institutes of Heart and Lung, Child Health, Dental Research, Environmental Health Sciences, General Medical Sciences, Mental Health, and Neurological Diseases and Stroke.

We know there's some research in the Clearinghouse on Smoking and Health at the Center for Disease Control and a good deal more involving smoking in NIOSH.

SMOKING AND HEALTH RESEARCH

I'd like to ask, too, in order to make the roundup complete, that you have someone investigate and report on the smoking and health research being done by the VA, EPA, USDA and any others that you people know of.

I'd like a list of projects, the grantees and contractors, the individual costs for the latest year available and a progress report on those projects that have been under way for any length of time.

Dr. COOPER. The Center for Disease Control conducts a continuous survey of ongoing research in smoking and health, which is published on a biannual basis under the title "Directory of Ongoing Research in Smoking and Health." The 1974 directory lists 77 Government-sponsored research projects on smoking and health conducted by agencies outside of the Department of Health, Education, and Welfare. Of these projects, 73 are clinical or experimental in nature. Detailed information by sponsoring agency, project title, principal investigators, objectives, results to date or abstract, and financial support is provided for the record below.

[The information follows:]

Atomic Energy Commission

University of California, Berkeley, Department of Biochemistry, Berkeley, California 94720
Project Title: Mutagenicity of Cigarette Smoke Condensate.
Principal Investigator: Bruce N. Ames.
Objective: To examine cigarette smoke condensate and its fractions for mutagenicity.
Results to Date: Considerable mutagenic activity has been found in smoke condensate and also in the various fractions. Most of these compounds only become mutagens after activation by liver homogenate.
Project Dates: August 1971-continuing.
Financial Support: AEC (AT (04-3)-34PA 156).

U. S. Veterans Administration Hospital, Irving and University Streets, Syracuse, New York 13210.
Project Title: Studies of Endogenous Carbon Monoxide Production.
Principal Investigator: Stephen Arthur Landaw.
Objectives: To (1) study heme kinetics through the use of C-labeled CO production; (2) study red blood cell destruction in newborn infants through CO production; and (3) evaluate CO body burdens in smokers, with special reference to induced erythrocytosis, altered plasma volume, etc.
Results to Date: See reference.
Project Dates: July 1973-continuing.
Financial Support: NHLI (5K4 HL17693-03); AEC and NASA (W7405-eng-48); AMA-ERF; U. S. Veterans Administration.
Reference: Landaw, S. A. "The Effects of Cigarette Smoking on Total Body Burden and Excretion Rates of Carbon Monoxide." Journal of Occupational Medicine 15 (3):231-235, March 1973.

AEC, Oak Ridge National Laboratories, Building 9211, P. O. Box Y, Oak Ridge, Tennessee 37830.
Project Title: NCI Tobacco Smoke Bioassay Research Project.
Principal Investigators: P. Nettesheim, M. Guerin, J. Kendrick, J. R. Stokely, and W. L. Maddox.
Objective: To develop bioassay systems for testing tobacco products with respect to their relative toxicity and carcinogenicity.
Results to Date: Numerous experiments in hamsters demonstrated that breathing through an intralaryngeal cannula increases lung deposition of radiolabeled smoke 2-3 fold over nose breathing. This increase is due mostly to cannulated hamsters maintaining a regular respiratory rate and tidal volume during exposure, whereas nose breathers show apneustic breathing patterns. Small-scale chronic studies employing an intermittent smoke generator device show that 10-12 code 9 cigarettes per day in the hamster, and seven per day in the rat can be given successfully for long periods. Acute and chronic toxicity tests show that hamster strains vary considerably

in their resistance to cigarette smoke toxicity. Survival for example in hamster line 87.20 is twice as great as in the conventional Syrian golden hamster. Smoke inhalation tests in rats (SPF Fischer 344 females) have been conducted for six months with no apparent respiratory infections to this point. The use of smoke tracers for determining relative dose appears justifiable when exposure conditions are fairly similar. Preliminary surveys of the smoke exposure chamber contents show that the gas phase composition, not including the major gases involved in normal respiration, is remarkably constant for as much as 60 seconds at the smoke concentration in common use. In the absence of animals, changes are so small as to be barely detectable using existing methodologies. In the presence of animals, the overall gas-phase component (as measured primarily by acetaldehyde, acrolein, and isoprene) decreases in quantity during a 40-second stand time, but the composition remains essentially unchanged. When artificially long stand periods (as long as several minutes) in the presence of animals are used, minor changes in composition do occur. Rat grafts, exposed to polycyclic hydrocarbons or cigarette smoke condensate, develop epithelial hyperplasia, dysplasia, and squamous metaplasia in 1-3 weeks. Methylcholanthrene or benzo(a) pyrene (5 mg) induce invasive squamous cell carcinoma in rat grafts after 26-35 weeks.
Future plans: Major emphasis will be placed on large-scale testing or chronic inhalation exposure schemes to produce maximum lung deposition and minimum toxicity in hamsters and rats. Efforts will continue to improve existing chronic exposure methodology and improvements will be incorporated in ongoing studies. Considerable progress should be made toward developing a system that allows constant monitoring of the gas phase and particulate components of smoke offered to and accepted by the animal. Studies will continue with the tracheal graft technique to determine its usefulness as a carcinogenic bioassay model for both cigarette smoke condensate and whole cigarette smoke.
Project Dates: July 1971-continuing.
Financial Support: NCI (W7405-eng-26); AEC.

Battelle Memorial Institute, Pacific Northwest Laboratories, P. O. Box 999, Richland, Washington 99352
Project Title: Combined Effects of Smoking and Inhalation of Uranium Ore Dust and Radon Daughters in Dogs.
Principal Investigator: Bruce O. Stuart.
Objective: To determine the roles of inhaled cigarette smoke, uranium ore dust, and radon daughters during lifespan daily exposures of dogs in the production of lung pathology related to lung cancer in uranium miners.
Results to date: This long-range study will progress for some time before lung pathology will be fully developed. Current findings include pleural thickening, septal fibrosis, endothelial proliferation, alveolar epithelial hyperplasia, vesicular emphysema, and squamous metaplasia with atypical nuclei.
Future plans: Daily exposure of experimental animals in lifespan studies will continue to determine the pulmonary pathology resulting from inhalation of controlled levels of uranium mine air contaminants and cigarette smoking by techniques that closely simulate human patterns of smoking, including further measurements of deposition.
Project Dates: June 1968-continuing.
Financial Support: AEC (AT(45-1)-1830).

U. S. Department of Agriculture (Unspecified)

USDA, ARS, Tobacco Laboratory, Plant Genetics and Germplasm Institute, Room 104, South Building, Beltsville, Maryland 20750
Project Title: Improvement of Chemical and Physical Factors for Production of Safer Smoking Tobacco
Principal Investigators: T. C. Tso, Amber L. S. Cheng, and T. Sorokin
Objective: To find ways to improve smoke properties to obtain tobaccos less harmful to health.
Results to Date: Wax, phytosterols, polyphenols, and several nitrogenous compounds were found undesirable. A novel method of leaf curing was developed to improve leaf usability and save labor. Variation of chemical composition was observed according to genetical, cultural, and curing processes. Alkaloids, fatty acids, alcohols, esters, wax, and phytosterols including water-soluble sterols were studied. Residue level of maleic hydrazide and its transfer and decomposition to smoke were investigated. CRIS Progress Report (June 6, 1973). Final results are subject to completion of the investigation.
Future Plans: Tissue and cell culture work has been initiated, and various media with different biologically active compounds are under evaluation.
Financial Support: USDA

North Carolina Agricultural and Technical State University, Department of Chemistry, Greensboro, North Carolina 27411
Project Title: Degradation of Maleic Hydrazide, Endosulfan, and Pesticides in Cigarette Mainstream and Sidestream Smokes.
Principal Investigator: N. M. Chopra.
Objectives: To (1) isolate, identify, and estimate quantitatively the breakdown products of maleic hydrazide and endosulfan in cigarette mainstream and sidestream smokes; (2) investigate various factors influencing the breakdown of pesticides in tobacco and cigarette smokes; (3) investigate the reaction mechanisms involved in the breakdown of pesticides in tobacco and cigarette smokes; and (4) evaluate the toxicity of the pesticide breakdown products that might be found in cigarette smokes.
Results to Date: During the smoking process the more volatile compounds have a better chance of not being destroyed. The higher the amount of pesticide present in tobacco, the greater is the percentage loss of the pesticide upon smoking. Smoking being a pyrolytic reaction of very short duration, "primary," "secondary", and "tertiary" reactions take place in the order given. Reactions that have lesser energy requirements occur more readily than those that have a higher energy requirement. In the instance of 2,2-di-(p-chlorophenyl)-1,1-dichloroethane (p,p-TDE) treated tobacco smokes, some is also formed by dehydrogenation of the parent compound in the tobacco smokes.
Future plans: The study will be extended to other pesticides.
Project dates: May 1972-1976.
Financial Support: North Carolina Agricultural and Technical State University; USDA (216-15-105309-075 and 316-15-08309-108).

Agricultural Research Service

USDA, Germfree Life Research Center, Fort Lauderdale, Florida 33314
Project Title: Bioassay of Experimental Cigarettes With Virus-Infected Animals.
Principal Investigators: T. C. Tso and J. Warren.
Objectives: To (1) develop and perfect a short-term bioassay system using

sarcoma virus in either quail or mice for evaluating cocarinogenicity of cigarette smoke condensate, and (2) determine and compare biological activities of cigarette smoke condensate from 32 experimental tobaccos varying in genetic background and stalk positions.
Results to Date: Groups of quail were inoculated intramuscularly into the pectoral muscle with 0.1 ml (2.0 mg) of tobacco smoke condensate in DMSO. Six days later, graded doses of RSV-O in a volume of 0.1 ml were injected into the same site. The Moloney sarcoma virus testing was also begun. The effect of tobacco smoke condensate in the quail RSV system was observed. Preliminary results indicate that this system may be applicable to evaluation of components of carcinogenic nature. CRIS Progress Report (February 1971-February 1972). Final results are subject to completion of the investigation.
Project Dates: June 25, 1971-June 14, 1973.
Financial Support: ARS, PSRD (12-14-100-11014(34)).

USDA, ARS, Richard B. Russell Agricultural Research Center, P. O. Box 5677, Athens, Georgia 30604
Project Title: Biologically Active Constituents of Tobacco Smoke.
Principal Investigator: W. J. Chamberlain.
Objective: To isolate and identify new physiologically active constituents of tobacco smoke based on tumorigenic effects of smoke fractions in experimental animals.
Results to Date: Investigations have been initiated on the isolation and identification of constituents of fractions and subfractions of cigarette smoke condensate. A weak acid fraction and a methanol-water soluble subfraction of the neutral portion of smoke condensate have been subjected to further chromatographic separations. This work will be continued. CRIS Progress Report (July 1971-June 1972). Final results are subject to completion of the investigation.
Project Dates: February 2, 1972-February 2, 1977.
Financial Support: USDA, ARS.

USDA, ARS, Richard B. Russell Agricultural Research Center, P. O. Box 5677, Athens, Georgia 30604
Project Title: Radiation Effects on Tobacco and Tobacco Smoke.
Principal Investigator: O. T. Chortyk.
Objective: To determine the biological activities and chemical compositions of tobacco and tobacco smoke from gamma-irradiated tobacco in an effort to reduce the tumorigenic activity of cigarette smoke.
Results to Date: The study is in a preliminary phase.
Project Dates: March 22, 1973-March 22, 1978.
Financial Support: USDA, ARS.

USDA, ARS, Richard B. Russell Agricultural Research Center, P.O. Box 5677, Athens, Georgia 30604
Project Title: Pyrolysis of Tobacco Leaf Constituents and Related Materials.
Principal Investigators: W. S. Schlotzhauer, A. F. Haeberer, and E. B. Higman.
Objectives: To determine the pyrolytic products of selected tobacco leaf constituents and related materials and evaluate their influence on biological activity, flavor, and aroma.
Results to Date: The major source of polyaromatic hydrocarbons, including the carcinogen 3,4-benzopyrene, in tobacco pyrolysates has been determined to be the hexane-extractable portion of cured leaf. The tumor-promoting

and cilia-toxic volatile phenols were found to arise from pyrolysis of the brown pigments and carbohydrates present in leaf. Pyridine and quinoline bases arise from pyrolysis of leaf alkaloids and amino acids. A new analytical method has been developed for the determination of maleic hydrazide (a systemic growth regulator) in both tobacco leaf and tobacco smoke condensate. Triglycerides, alcohols, and esters were found to be precursors of homolgous series of alkenes and alkanes. Phenol was found to be a major pyrolysis product of the tobacco flavoring agent, vanilla. Coumarin was found to survive a pyrolysis temperature of 840°C when deer tongue powder and tonka bean powder were pyrolyzed.
Future Plans: Pyrolysis of other selected tobacco constituents will be carried out.
Project Dates: December 1971-1976.
Financial Support: ARS.

SDA, ARS, Richard B. Russell Agricultural Research Center, P. O. Box 5677, Athens, Georgia 30604
Project Title: Preparation of Smoke Condensate Fractions for Biological Assay.
Principal Investigator: A. P. Swain.
Objective: To develop and apply methods of fractionation to tobacco smoke condensate to prepare samples on a large scale for the determination of carcinogenic and cocarcinogenic activities by biological assay.
Results to Date: Work has been initiated on developing a new scheme of separation for cigarette smoke condensate fractions for biological activity assay. These condensate fractions will be used to establish the response of animals in mouse-back painting experiments. These experiments are being conducted under a newly established bioassay program at this laboratory and will serve to continue previous phases of this in-house tobacco-health research program. CRIS Progress Report (July 1971-June 1972). Final results are subject to completion of the investigation.
Project Dates: March 9, 1972-March 9, 1977.
Financial Support: USDA, ARS.

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506 and USDA, Agricultural Research Station, Southern Region, Tobacco Research Laboratory, Oxford, North Carolina 27565
Project Title: Studies on the Factors Regulating the Quantity and Quality of Brown Pigments in Tobacco Leaves and Biological Actions of Cigarette Smoke
Principal Investigators: S. J. Sheen and James F. Chaplin
Objectives: To (1) isolate and characterize brown pigments in air-cured tobacco; (2) determine their biological activity in smoke; and (3) examine the genetic factors regulating their amount and quantity in Nicotiana species and hybrids.
Results to Date: The study is in a preliminary phase.
Project Dates: June 1973-1975.
Financial Support: USDA, ARS (12-14-7001-69).

University of Kentucky, Department of Plant Pathology, Lexington, Kentucky 40506 and USDA, Agricultural Research Service, Southern Region, Tobacco Research Laboratory, Oxford, North Carolina 27565
Project Title: Investigations on the Effects of Microorganisms on the Chemical Composition of Leaf Tobacco
Principal Investigators: S. A. Ghabrial and James F. Chaplin.
Objectives: To (1) determine the chemical effects of adding different com-

binations of yeast and bacteria to tobacco leaf, and (2) test the biological activity of the smoke.
Results to Date: The study is in a preliminary phase.
Project Dates: June 1973-1975.
Financial Support: USDA, ARS (12-14-7001-70)

University of Kentucky, College of Medicine, Department of Medicine, Lexington, Kentucky 40506
Project Title: Influence of Aqueous Extract of Cigarette Smoke Condensate (AECSC) on Sarcoma Induced by Benzo(a)pyrene (B(a)P) or the Non-aqueous Fraction of Cigarette Smoke Condensate (NAECSC) in the Sprague-Dawley Rat.
Principal Investigator: K. L. Sydnor.
Abstract: B(a)P is a powerful carcinogen when administered by subcutaneous injection but a relatively weak one when fed. A dose-relationship for sarcoma induction was observed when 1, 2, or 4 mg was administered in sesame oil on alternate days for 30 doses. Higher doses accelerated tumor-induction time but the dose had to be increased 3- to 4-fold to change this parameter significantly. Administration of AECSC prepared from a commercial brand cigarette as drinking fluid (0.25 mg/ml 5 percent sugar solution) accelerated sarcoma induction, potentiated B(a)P-induced liver aryl hydroxylase and menadione reductase activities, and increased binding of radioactivity to the acetone-insoluble fraction of tissue removed from the site of injection. AECSC prepared from U.K. reference cigarettes, 1R1, had no influence on B(a)P-induced sarcoma but was comparable to commercial AECSC in other respects. When administered to rats given a subcutaneous injection of 2,4, or 8 mg NAECSC on alternate days for 30 doses, seven of 17 injected with the 8 mg dose and two of 12 injected with the 4 mg dose developed sarcoma, whereas one of nine injected with the 8 mg and three of 18 injected with the 2 mg dose and given sugar solution alone had tumors. Eight mg NAECSC appears to have the same order of tumor-inducing potency as 2 mg B(a)P, and is a complete carcinogen under these experimental conditions. Preliminary studies on inbred rat strains indicate that genetic factors determine the threshold of sensitivity to chemical carcinogens.
Project Initiation Date: June 23, 1967.
Financial Support: ARS (9484, 9527, 10321).

University of Kentucky, College of Medicine, Department of Pharmacology, Lexington, Kentucky 40506
Project Title: Metabolic Activation of Benzo(a)pyrene and Related Compounds in Rats.
Principal Investigator: James W. Flesher.
Abstract: Tritium-labeled benzo(a)pyrene was prepared by acid-catalyzed exchange. The labeled compound was administered to rats by stomach tube either alone or after oral administration of phenanthrene or phenol. Radioactivity was determined in selected tissues, urine, and feces after combustion by using the oxygen flask technique in a liquid scintillation counter. The uptake of radioactivity of selected tissues was decreased in rats pretreated with phenanthrene, whereas little effect was noted after pretreatment with phenol. The metabolism of benzo(a)pyrene by rat-liver homogenates as affected by oral pretreatment of rats with benzo(a)pyrene, phenanthrene, or phenol was investigated. Binding to cellular components by metabolites of benzo(a)pyrene was not affected by pretreatment with benzo(a)pyrene whereas metabolism of the compound was enhanced. Pretreatment with

phenanthrene decreased the binding to cellular components by metabolites of benzo(a)pyrene and decreased the amount of benzo(a)pyrene metabolized. Phenol decreased the metabolism of benzo(a)pyrene but did not decrease the binding of metabolities of benzo(a)pyrene to cellular components. When benzo(a) pyrene is incubated with rat-liver homogenates a metabolite was found which is indistinguishable from 6-hydroxymethylbenzo(a)pyrene on thin-layer chromatograms. This compound was shown to be a potent carcinogen. A series of compounds which are capable of conversion to 6-hydroxymethylbenzo(a)pyrene in vivo were synthesized. Each of these was shown to be a potent carcinogen. These results, taken together with our work on 7,12-dimethylbenz(a)anthracene, are in accord with the hypothesis that the formation of a hydroxymethyl metabolite is the first step in the chain of events which results in cancer.
Project Initiation Date: June 1966.
Financial Support: ARS (8328, 9516, 10994).

University of Kentucky, College of Medicine, Department of Medicine and Pharmacology, Lexington, Kentucky 40506
Project Title: Chromosomal Aberrations and Neoplasms-Slight Effect of Two Smoke Fractions
Principal Investigators: E. Douglas Rees, Amy Shuck, John Lowry, and Richard Wolfe
Abstract: It is well established experimentally that cigarette smoke condensate (CSC) is only weakly carcinogenic. Benzo(a)pyrene, one of a large series of polycyclic hydrocarbons (PCH), is a carcinogen but its concentration in CSC is not sufficient to account for the carcinogenicity of CSC on mouse skin. We have demonstrated in rats that for a PCH (40 mg/kg i.v.) series there is a correlation between the ability of a compound to damage chromosomes (breaks) and the ability to produce cancer. The study was extended to other types of compounds: 3,4 benzacridine (40 mg/kg i.v.) and B-propiolactone (100 mg/kg i.v.) caused relatively few chromosome breaks and relatively few cancers - consistent with results in the PCH series. Diethylnitrosamine (150 mg/kg i.v.) differed. Its effect on chromosomes was not large and few of the usual rat cancers (mammary, skin, leukemia, ear duct) result, but after 8-10 months liver cancers overwhelmed the hosts. The enriched aromatic fraction (150 mg/kg i.v.) and the II-2 (150 mg/kg i.v.) counter-current fraction (Izard et al.) of CSC produced a dramatic acute physiologic response but affected chromosomes slightly and had either no or slight carcinogenic effect. CSC-treated animals remained quite healthy. Lung tumors were not seen. Enhancement of the carcinogenic response by immunosuppressives (azathioprine, cortisol, and cyclophosphamide) was explored but the effect was small. Present work concerns detecting more subtle chromosomal lesions and more precisely locating sites of damage on individual chromosomes, especially following administration of subfractions of the enriched aromatic fraction.
Financial Support: ARS (11043(75)).

University of Kentucky, Medical Center, Department of Pathology, Lexington, Kentucky 40506
Project Title: Effects of Cigarette Smoke on the Dynamics of Pulmonary Morphology
Principal Investigator: Irene E. Roeckel.
Abstract: Extensive histopathologic evaluation and mitotic nuclear synthetic rate determinations of the bronchial epithelium in inbred mice with spontaneous high and low lung tumor incidence showed significant strain differences. The same strains subjected to intra-nasal application of

acrolein, benzpyrene, and tobacco smoke condensate also showed significant strain differences. No tumors were produced with tobacco smoke condensate, but 100 percent tumor induction occurred in the low spontaneous tumor incidence strain with benzpyrene. Prior to tumor induction there was a significant decrease in nuclear synthetic activity, a characteristic of the high tumor incidence strain. Since both strains are characterized by inducibility of the enzyme hepatic aryl hydrocarbon hydroxylase (AHH), an enzyme related to chemical carcinogenesis, experiments with fresh smoke inhalation currently in progress are including mice of a strain without inducible AHH. Tumors have been induced with long term administration of fresh reference cigarette smoke in AHH inducible animals, but not in mice lacking inducible AHH.
Project Initiation Date: July 1971.
Financial Support: ARS (12-14-100-10361(73)).

University of Kentucky, Department of Anatomy, Lexington, Kentucky 40506
Project Title: Preliminary Ultrastructural Study of Olfactory Epithelium in C57Bl/6J and SWR/J Mice After Acute Exposure to Cigarette Smoke
Principal Investigators: D. H. Matulionis and R. O. Lambson
Abstract: Olfactory epithelium of three groups of animals each consisting of C57Bl/6J and SWR/J mice was exposed once or twice daily to 10 percent 1R1 cigarette smoke for varying lengths of time and examined at the ultrastructural level. Group A animals were exposed to smoke from one cigarette once a day for six days, group B to three cigarettes twice a day for six days, and group C to one cigarette once a day for nine days. All animals were provided by the Tobacco and Health Research Institute (THRI) Core Service, Olfactory epithelia of group A C57Bl/6J and SWR/J experimental mice and of groups B and C SWR/J animals were normal. However, prominent alterations were noted in olfactory epithelium of all group B experimental animals and in 33 percent of group C animals. These alterations included: (1) reduced size and (possibly) number of olfactory vesicles which sometimes failed to protrude above the epithelial surface, and (2) greatly reduced numbers of olfactory vesicle sensory cilia. In the supportive cell population an abnormal electronlucent cell type was noted among the usually darker types. The number of apically situated mitochondria and smooth-membrane profiles was reduced in both cell types, and the usually distinct organelle-free apical ectoplasmic region was congested with a variety of organelles. Both cell types were frequently found protruding abnormally above the epithelial surface. Microbilli of supporting cells were reduced in number. Our present observations indicate that the olfactory epithelia in all mice of the same strain are not affected equally by acute smoke exposures. In affected animals the degree of morphological alteration suggests that normal olfaction might have been impaired. Strain differences in reaction to smoke insult suggest that susceptibility is genetically determined.
Project Initiation Date: July 1, 1972.

University of Kentucky, Department of Pharmacology, Lexington, Kentucky 40506
Project Title: Effects of Cigarette Smoke Inhalation on Chemical Characteristics of Lung Tissue and Secretions in Rats and Its Influence in Reducing Expectorant Activity.
Principal Investigators: H. A. Gordon and B. F. Schwartz.
Abstract: The purpose of this work was to evaluate the effects which subacute tobacco smoke exposure and expectorant drug action may have upon tissue constituents, and secretory and exudative substances of the lungs of laboratory rats. Smoke exposure consisted of three standard reference

cigarette smokings per day, over a seven day period, in our smoking apparatus for long range studies, using unanesthetized rats. Cycline of puffs was 10 sec smoke-air mixture breathing (10 percent), 50 sec air breathing, ten puffs per cigarette, with three cigarettes smoked consecutively. In the study dealing with expectorant activity, the rats inhaled the smoke of three cigarettes per day for seven consecutive days in a conscious, unanesthetized state. Half of the animals received daily subcutaneous injections of glyceryl guaiacolate (500 mg/kg body weight). The rats were sacrificed by decapitation eight hours after the last smoking period. From one-third of the animals, the lungs were removed and homogenized. The homogenate was lyophilized and held in desiccated form for chemical characterization. From the last third of the animal lung washings were obtained in order to study exudative and secretory substances in the tracheo-bronchial tree. Pulmonary edema was produced by perfusing a plasma substitute in the pulmonary vasculature, while alternately compressing and expanding the excised lungs. The foaming tracheal effluent (washings) was collected until 20 ml was obtained from each rat. This was lyophilized and stored in dry form for chemical analysis. The analytical work aimed at the characterization of mucous (sialic acids), ground substance, and exfoliated cell components (hexuronic acid) in conjunction with carbohydrates (hexosamine) in both lung homogenates and washings. This was complemented with an assay of ribonucleic acids and protein analysis. The results showed in terms of the lungs, that total weight, dry percent, protein content, hexosamine, and ribonucleic acids (the latter reflecting the matabolizing cell mass of the lungs) were essentially the same in smoke exposed and control groups. Sialic and hexuronic acids, the characteristic components of mucopolysaccharides, indicated elevated values in the lungs of smoke-exposed rats. Tracheobronchial washings (which portray the accumulation of desquamative, secretory, and exudative substances in the airways), reflected similarity between smoked and non-smoked animal groups. Here, only ribonucleic acid levels appeared elevated in smoke exposed rats. In conjunction with this work it was found that subacute smoke exposure reduced the expectorant action of glyceryl guaiacolate.

Project Initiation Date: July 1971.

Financial Support: USDA, ARS.

University of Kentucky, Tobacco and Health Research Institute, Lexington, Kentucky 40506

Project Title: Smoke Analysis, Condensate Preparation, and Condensate Fractionation.

Principal Investigators: J. F. Benner, C. K. Keene, and T. W. Holt.

Abstract: Services offered by the Tobacco and Health Research Institute Core Service Chemistry section include (1) routine analytical services, (2) non-routine analytical services, (3) studies to obtain fundamental information on smoke composition, smoking procedures, and smoke manipulation techniques, (4) routine smoke condensate preparation, (5) condensate fractionation, (6) bioassay sample preparation, and (7) reference compound preparation and purification. Analytical services are provided to evaluate the smoke chemistry of experimental tobaccos and tobacco product modifications developed by the basic research projects within the program. The smoke condensate laboratory prepares smoke condensate, condensate fractions, and bioassay samples for program investigators. Emphasis is placed on smoking and trapping systems which cause the minimum alteration of the chemical composition of the smoke. The location of smoke components in the fractionation scheme as described by Izard and co-workers is under current investigation.

Project Initiation Date: June 1972.
Financial Support: KTRB (002); ARS (10326(73)).

University of Kentucky, Chemistry Department, Lexington, Kentucky 40506
Project Title: Pyrolysis of Soybean Protein and an Amino Acid Mixture Having the Same Amino Acid Composition.
Principal Investigators: Walter T. Smith, Jr., and John M. Patterson.
Abstract: Soybean protein and a mixture of amino acids corresponding to the composition of soybean protein were pyrolyzed at 850 degrees C in a nitrogen atmosphere. Noncondensable gaseous products and 24 components of the neutral fraction of the pyrolyzate have been identified. In addition, the amounts of the individual components of the neutral fraction have been determined. Identified components account for over 85 percent of the neutral fraction and include naphthalene (24 percent from amino acid mixture, 20 percent from protein), benzonitrile (14 percent, 21 percent), indole (7.2 percent, 8.5 percent), phenanthrene with anthracene (5.7 percent, 3.9 percent), indene (4.4 percent, 2.5 percent), acenaphthylene (4.4 percent, 2.9 percent), 1-naphthonitrile (4.3 percent, 6.0 percent), 2-naphthonitrile (3.9 percent, 5.2 percent) and pyrene (2.6 percent, 1.9 percent). The same neutral compounds were formed from the pyrolysis of the soybean protein and from the amino acid mixture. The total amount of neutrals formed from the protein pyrolysis was greater than from the amino acid pyrolysis, but for most components, the relative amounts formed in each pyrolysis were approximately the same. Benzonitrile and the naphthronitriles were formed in larger amounts from the protein than from the amino acid mixture. The results indicate that data obtained from pyrolysis of amino acid mixtures are useful in predicting the composition of protein pyrolyzates. When the soybean protein and the amino acid mixture were subjected to controlled pyrolysis at 600 degrees C in apparatus designed to simulate destructive distillation processes which occur in a cigarette, the nature of the neutral condensate was significantly different from that obtained in the classical 850 degree C pyrolysis. In addition to aromatic compounds, a variety of amides and nitriles was formed. Controlled pyrolysis of the amino acid mixture gave a larger number of components in the pyrolyzate than did similar pyrolysis of the protein.
Project Initiation Date: June 23, 1971.
Financial Support: ARS (12-14-100-10997(73)).

University of Kentucky, Chemistry Department, Lexington, Kentucky 40506
Project Title: Investigations on the Pyrolytic Interaction Between Maleic Hydrazide and Tobacco
Principal Investigators: John M. Patterson and Walter T. Smith, Jr.
Abstract: Our previous work on the pyrolysis of maleic hydrazide (MH) at 850 degrees C showed that pyrolysis of this compound resulted in the production of health-related substances such as HCN, CO, NH_3, naphthylamines, phenols, and benzopyrenes. In the present work the fate of MH when it is subjected to controlled pyrolysis conditions is being investigated. For this work we are using the apparatus which we have designed to simulate the pyrolytic and destructive distillation conditions which occur in the region ahead of the coal in a cigarette. In order to determine the possible influence MH has on the composition of simulated tobacco smoke condensate, we are pyrolyzing MH-tobacco mixtures in this controlled pyrolysis apparatus. It is desirable to select pyrolytic conditions such that the ratio of MH to nicotine in the condensate is similar to that obtained from cigarettes. A convenient analytical method for

determining MH in both tobacco and condensate is thus necessary. Analytical procedures investigated include derivatization methods for analysis by gas-liquid partition chromatography (glpc) and colorimetric methods based on the condensation of hydrazine with p-(dimethylamino)benzaldehyde. For the glpc methods, we have studied the conversion of MH to its N- and O-methyl derivatives and also its conversion to a trimethysilyl derivative. The silylation method showed potential as an analytical procedure and modification of a previously reported colorimetric method produced satisfactory results for our purpose. Preliminary pyrolyses of MH and MH-tobacco mixtures (containing 2.5 percent and 5.0 percent MH) under controlled conditions have been carried out.
Project Initiation Date: June 24, 1972.
Financial Support: ARS (12-14-100-11052(75)).

University of Kentucky, Tobacco and Health Research Institute, Lexington, Kentucky 40506
Project Title: Investigations on the Effect of Tobacco Smoke Constituents on Rodent Tracheal Rings.
Principal Investigator: Grace M. Donnelly.
Abstract: The current project had its start in one of the first University Tobacco and Health Project funded by ARS. The initial objective was to utilize tracheal rings in an organ culture system for the purpose of developing a rapid, in vitro, bioassay system. Information concerning the cellular proliferation kinetics of the tracheal epithelium, the relationship of tobacco to histological and cytological changes, the sequence of development of the ciliated cell, the effect of tobacco on protein inhibition in the trachea, and the development of a routine ciliostasis bioassay has resulted from these projects. Tobacco samples supplied by Core Services are now monitored on a regular basis. Ciliostasis times for experimental cigarettes are compared with the 1R1 and a chemical standard. An optical scanning, data gathering, and data input system, which can accommodate several different experimental designs is being utilized. Results are analyzed and compared with results from other bioassay systems in operation within the Tobacco and Health Institute.
Project Initiation Date: June 1967.
Financial Support: ARS (12-14-100-11018(73)).

University of Kentucky, Medical Center, Department of Surgery, Lexington, Kentucky 40506
Project Title: Investigations on the Effect of Tobacco Smoke Constituents on Cellular Changes in Mouse Tissues.
Principal Investigator: William Meeker.
Abstract: Studies are in progress to develop an in vitro system for carcinogenicity of tobacco smoke condensate fractions prepared from University of Kentucky 1A1 reference cigarettes. Morphologic changes indicative of malignancy have been sought. Also, tumor development in animals following implantation of cultured organ fragments or dispersed cells has been used as a criterion of malignant change. Two in vitro assay systems have been utilized. The first, patterned after the classic experiments of Berwald and Sachs, involves the preparation of mouse embryo tissue cultures by trypsinization of minced embryos, and the exposure of these tissue culture cells to (1) 3-methylcholanthrene, a known carcinogen; (2) water-insoluble fraction of tobacco smoke condensate; and (3) ethanol used to dissolve the test substances for a short period (2.5 hours). In experiments to date there has been no evidence of transformation in any cultures in this set of experiments. The second in vitro assay system is patterned

after the model designed by Laws and Flaks to study chemical carcinogenesis. In this system organ cultures were made of explants of newborn mouse lungs. These explants were exposed to tobacco smoke condensate water insoluble fraction in ethanol in varying concentrations; 3-methycholanthrene; and solvent (ethanol) only for eight days. Fragments were then implanted subcutaneously in mice and these mice were observed for tumor occurrence. Untreated organ culture fragments were also implanted into intact mice. No tumors have been observed to date.
Project Initiation Date: June 24, 1971.
Financial Support: ARS (11006(73)).

University of Kentucky, T. H. Morgan School of Biological Sciences, Lexington, Kentucky 40506
Project Title: Studies of the Effects of Tobacco Smoke and Its Components on Various Aspects of Mitochondrial Function.
Principal Investigators: C. Gairola, B. J. Wilkinson, and M.I.H. Aleem
Abstract: The effects of various smoke fractions on controlled (state 4) and active (state 3) respiration, phosphorylating ability (ADP:O ratios), and intactness (respiratory control ratios) of mitochondria have been studied. Mitochondria have been prepared from a variety of mammals, mammalian organs, and yeast, but mainly from rat liver. The water soluble fraction (W/S) inhibited state 3 and 4 respiration in all types of mitochondria. Water insoluble (W/Ins) and Izard (I_1, I_2, I_3, II_1, II_2 and II_3) fractions inhibited state 3 respiration of rat liver mitrochondria. The state 4 respiration was stimulated or inhibited depending on the concentration and fraction used. Respiratory control ratios and ADP:O ratios were adversely affected by various fractions. Spectroscopic studies indicated that the W/S fraction inhibits at various sites (e.g. between cytochromes b and c, and cytochromes c and a + a3). Certain energy driven reactions in cyanide blocked submitochondrial particles were inhibited by W/S and W/Ins fractions, i.e. effects not attributable to cyanide. Comparative studies on the mitochondria isolated from mice treated with tobacco smoke preparations showed no appreciable differences to mitochondria from control animals. On the basis of the results described above a bioassay for the routine evaluation of tobacco smoke preparations from different experimental cigarettes has been developed. The effects of pure compounds known to occur in smoke on mitochondrial metabolism will also be reported.
Project Initiation Date: July 1971.
Financial Support: ARS (12-14-100-11005(73)).

University of Kentucky, Departments of Oral Biology and Agronomy, Lexington, Kentucky 40506 and Florida State University, Department of Biological Sciences, Tallahassee, Florida 32306
Project Title: Investigations on the Effect of Tobacco Smoke in the Formation of a Microbial Membrane-bound Electron Transport System.
Principal Investigators: A. N. Tucker, T. T. Lillich, R. B. Griffith, and D. C. White.
Abstract: One of the components in tobacco smoke which most markedly affects the formation and function of membranes is benzo(a)pyrene (BAP). In our previous work BAP has shown marked effects on the integration of membrane-bound respiratory pigments into a functional sequence, an activity not seen with less carcinogenic isomers of BAP. Cytochrome oxidase o is the terminal electron acceptor for the membrane-bound electron transport system. In the presence of BAP its synthesis is depressed, the stability in the membrane is much decreased, and its ability to function as the terminal member of the respiratory chain is markedly decreased. The reduction of the func-

tion of the respiratory complex is one of the constant features of the neoplastic transformation, hence, the relevance to studies of tobacco and health. It has been shown that depriving a glycerol auxotroph of Staphylococcus aureus of glycerol markedly disturbs lipid metabolism and induces similar changes in the functionality of cytochrome oxidase o as BAP, suggesting a role for this carcinogenic polynuclear hydrocarbon in the disruption of the normal membrane organization. With this system, hopefully a clearer idea as to the molecular action of the smoke carcinogen can be gained.
Project Initiation Date: July 1972.
Financial Support: ARS (12-14-100-11040(75)).

University of Kentucky, School of Biological Sciences, Lexington, Kentucky 40506
Project Title: Biological Effects of Tobacco Smoke and Its Constituents on Cells, Tissues, Organs, and Chromosomes of Plants
Principal Investigators: P.S. Sabharwal and P. R. Bhalla.
Abstract: During the last four years investigations were undertaken in our laboratory on the effect of tobacco, its fractions, and some components on plant cells and tissues to develop an improved rapid bioassay method for tobacco smoke. Increasing concentrations of water soluble fraction of tobacco smoke condensate reduced the rate of cytoplasmic streaming. Known carcinogens such as benzo(a)pyrene induced cell divisions in callus cultures of Nicotiana tabacum while some tobacco smoke components such as benzo(e)-pyrene, dibenz(a,h) anthracene, and pyrene stimulated vegetative buds. Whole smoke and some of its components proved detrimental to the growth and flowering of a duckweed (Lemna gibba) and germination rate of seeds. Recent studies on the cytological effects of tobacco smoke, its fractions, and some components revealed that there is decrease in mitotic frequency, induction of mitotic irregularity, and chromosomal breakage when roots of garlic, onion, and broad beans are exposed to tobacco smoke and some of its components. These studies reveal that tobacco smoke, its fractions, and components have a definite biological effect on plant chromosomes, cells, tissues, and organs. Since these responses are dose related, they might eventually lead to the development of a rapid bioassay procedure for tobacco smoke and its components.
Project Initiation Date: June 23, 1969.
Financial Support: ARS (12-14-100-11004(73)).

University of Kentucky, Tobacco and Health Research Institute, Lexington, Kentucky 40506
Project Title: Current Status of the Sebaceous Gland Suppression-Hyperplasia Bioassay
Principal Investigators: R. B. Griffith, G. M. Donnelly, and S. Schell.
Abstract: This bioassay has been developed to the point where six groups of ten animals each can be examined routinely each week. With two concentration levels of reference cigarette condensate and one concentration level of an experimental condensate, this permits the examination of four experimental samples per week. During the past year small but very important modifications have been made in the technique as described at the 1972 Workshop Conference. Reproducible results can be obtained and work with benzo(a)pyrene, promoters and experimental samples would indicate that this is an important and valid bioassay. A cycling of the results obtained with condensate from the reference cigarette with time has been noted. This response corresponds to the cycling of an environmental variable, which is now being investigated experimentally. Since

the test involves a comparison of the relative activity of experimental samples with that of the reference cigarette, the cycling has not prevented valid comparisons. Data for various experimental samples and condensate fractions will be presented.
Project Initiation Date: June 1971.
Financial Support: ARS (12-14-100-11053(75)); KTRB Core Services.

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Tobacco and Health Related Research Involving Breeding, Transfer, and Biosynthesis of Photosterols in Tobacco
Principal Investigators: D. L. Davis and C. Grunwald.
Abstract: The inheritance of tobacco sterols was studied by using a seven parent diallel. Analysis of the data revealed that the mode in inheritance of sterol levels in tobacco was predominately controlled by additive gene action; however, some evidence indicates the presence of partial dominance. The distribution of sterols within the tobacco plant has been investigated extensively. Total sterol levels, as well as the ratio of stigmasterol vary within the plant. Cigarettes manufactured from lines with different sterol levels, plus sterol spiked material were smoked for sterol transfer studies. Cholesterol was found in cigarette smoke condensate, both in the free and bound form (glycosidated and esterified). Approximately 17 percent of the total endogenous sterol was transferred from the cigarette tobacco to its condensate. As exogenous sterol increased, there was a decrease in the transfer percentage. When high sterol levels (4 mg/g dry weight) were applied to the leaf surface, only 60 percent could be recovered in the manufactured cigarette. From the study using nine tobacco lines that differed in sterol content, it was found that the levels of sterol components in the condensate was correlated with levels in the leaf.
Project Initiation Date: June 1970.
Financial Support: ARS (12-14-100-10317(34)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Determining the Effects of Nitrogen Nutrition on the Fatty Acid and Phytosterol Composition of Tobacco Plants.
Principal Investigator: C. Grunwald.
Abstract: Nicotiana tabacum L. var. Burley 21, low alkaloid (LA) Burley 21, and low phenol (LP) Burley 21 were field grown under various nitrogen fertilizations and analyzed for total carotenoids, total chlorophyll, total lipid, fatty acids, and sterols. Nitrogen fertilization had no effect on carotenoid content but increased the chlorophyll content. LP Burley 21 had a higher chlorophyll and carotenoid content than normal Burley 21 but LA Burley 21 had the highest chlorophyll content. In all cases the upper leaves contained more carotenoid and chlorophyll than the lower leaves, but the upper leaves were lower in sterol content. LA Burley 21 had the highest sterol content; LP Burley 21 the lowest. Generally, higher sterol levels were found at low nitrogen fertilization. The individual sterol composition of Burley 21, LA Burley 21, and LP Burley 21 was very similar. The LA Burley 21 line was generally lowest in total crude lipids; however, the fatty acid content was highest. Cultural practices influence the lipids and sterol composition of Burley tobacco, and may influence the smoke composition which in turn may influence biological activity.
Project Initiation Date: June 1971.
Financial Support: ARS (12-14-100-10362(34)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506

Project Title: Determination of the Effect of Genetical Background and Nitrogen Nutrition on the Polyphenols and Carbohydrates Composition of Tobacco Plants.
Principal Investigator: S. J. Sheen.
Abstract: Air-cured leaves from three stalk positions of three Burley 21 breeding lines cultured with 100, 200, and 300 pounds of nitrogen fertilizer per acre were analyzed for the concentration of polyphenols, carbohydrates, and related compounds. Starch was not detected in the leaf samples. Low nitrogen fertilization enhanced polyphenol accumulation. Concentrations of polyphenols and brown pigments were distributed in a decreasing gradient from upper to bottom stalk positions. Distribution of cellulose content showed a reverse pattern. Lignin content was lowest in the middle leaves. In comparison to Burley 21, Burley 21 LA (low alkaloid genotype) contained more polyphenols and carbohydrates, while Burley 21 LP (low polyphenol genotype) was low in the amount of these compounds except soluble reducing sugars. Results point to the importance of nitrogen fertilization and leaf grades with respect to chemical composition. The low alkaloid genotype of burley tobacco increases brown pigments and lignins, whereas Burley 21 LP line appears to be an improved genotype with respect to the concentration of these leaf constituents, all of which are suspected precursors of tumorigenic agents in cigarette smoke.
Project Initiation Date: June 16, 1971.
Financial Support: ARS (12-14-100-10363(34)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Nitrogenous Fractions in Cured Leaf of Three Burley 21 Genotypes as Influence by Nitrogen Fertilization.
Principal Investigators: J. L. Sims and W. O. Atkinson.
Abstract: Three varieties of burley tobacco consisting of Burley 21 (normal alkaloid and polyphenol content), LA Burley 21 (low alkaloid line), and LP Burley 21 (low polyphenol line) were grown in a field experiment at the University of Kentucky South Farm during the summer of 1971. Fertilizer variables imposed on each variety included three levels of NH_4NO_3. After curing, subsamples of leaf were dried and ground for analytical analysis. Nitrate N, protein N, total N, total alkaloids, and total volatile bases were determined on the leaf samples. Concentrations of all measured constituents were the same for the Burley 21 and low polyphenol variety. Concentrations of nitrate N were about 25-50 percent lower and of protein 25-50 percent higher in the low alkaloid line than the other varieties. Total volatile bases in the low alkaloid variety were about half those in other varieties. Values for total N and total alkaloids were lower in samples of LA Burley 21 than either Burley 21 or LP Burley 21. No fertilization appeared to increase protein, nitrate, and total N concentration of the low alkaloid line but had no significant effect on alkaloid or total volatile bases of this variety during this year.
Project Initiation Date: July 1971.
Financial Support: ARS (12-14-100-10359(34)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Maleic Hydrazide Residues and Isoprenoid Leaf Constituents in Burley Tobacco (Nicotiana Tabacum L.) Genotypes
Principal Investigators: D. L. Davis and C. Grunwald.
Abstract: The tobacco was grown, treated, harvested, and sampled during the first period of the contract. The apparatus for determining maleic hydrazide residue levels was constructed. Samples collected seven days

after treatment were analyzed for MH residue for two burley varieties, three stalk positions, and two rates of MH application. Ky 14 had higher residue levels than By 21. Decreasing levels of residue were recorded for the top, bottom, and middle stalk positions, respectively. The lower level of residue in the middle of the plant cannot be explained at the present time. The lower rate of application resulted in lower residue levels as expected; however, differences in relative amounts differed with variety and stalk position. Effective sucker control was obtained for both rates of MH application. The pertinence of this work to tobacco and health is the determination of residue levels of a health suspect compound and the development of practical means of reducing the residue level while maintaining satisfactory sucker control.
Project Initiation Date: June 1972.
Financial Support: ARS (12-14-100-11042(34)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Investigations on Changes in Smoke Composition by Use of Chemical Modifiers and Solvent Extraction of Tobacco.
Principal Investigator: H. R. Burton.
Abstract: Research in this laboratory is concerned with the alteration of cigarette smoke by the physical and/or chemical modification of tobacco. To date, smoke analytical data from 115 chemically treated tobaccos have shown that the addition of chemicals to tobacco can significantly reduce the TPM, tar, nicotine, phenol, cresol, and benzo(a)pyrene content of the smoke. Thermal analysis techniques, such as TGA, DTA, and activation energies, are useful for determining the influence of tobacco modifications on the thermal decomposition patterns of tobacco. The data from the above studies show that there are relationships between the thermal analysis data and smoke composition from the chemically treated tobacco, varieties of tobacco, and types of tobacco. Reference tobacco has also been modified by extraction techniques, and the smoke analytical data from these tobaccos will be interpreted with respect to future product modifications that should be made. Analysis of the effluent gas from the thermal analysis of tobacco has been used to determine the effect of tobacco modifications on the formation of CO, CO_2, CH_4, and other lower molecular weight gases. From the thermal data of these modified tobaccos and their extracts it has been found that it is possible to fractionate the leaf extracts into fractions which have well defined thermal decomposition characteristics.
Project Initiation Date: 1971.
Financial Support: ARS (12-14-100-11009(73)).

University of Kentucky, Plant Pathology Department, Lexington, Kentucky 40506
Project Title: Studies on the Fermentation of Burley Tobacco.
Principal Investigator: S. A. Ghabrial.
Abstract: Samples of air-cured Burley tobacco variety Ky 10 were exposed to simulated fermentation conditions. The number and kinds of bacteria occurring on the leaf prior to, during, and after fermentation were determined. The bacterial count which was initially 7.0×10^6 increased to a maximum of 5.4×10^6 during fermentation. Of the several bacterial isolates present on the leaf prior to fermentation, only a single isolate, micrococcus sp., was predominant during fermentation. In addition to the increase in bacterial count, exposure of Burley tobacco leaf to fermentation conditions resulted in an increase in pH and a decrease in both total alkaloids and total nitrogen. Addition of yeast cultures to fermenting Burley

tobacco resulted in a still further increase in bacterial counts. This effect, however, was dependent on the yeast isolate added, the moisture content of tobacco leaf, and the ambient temperature. The objective of this research project is to develop a biological method for the modification of tobacco leaf composition based on the activities of microorganisms and through the application of fermentation techniques.
Project Initiation Date: June 15, 1971.
Financial Support: ARS (12-14-100-10364(51)).

University of Kentucky, Department of Community Medicine, and Tobacco and Health Research Institute, Lexington, Kentucky 40506
Project Title: Investigations on the Role of Mycotoxins in Smoke.
Principal Investigators: Ernest W. Chick and John Benner
Abstract: The brine shrimp bioassay has been found to be a sensitive measure of toxicity of Aflatoxins B_1 and G_1, ochratoxin, and diacetoxyscirpenol, but at this time appears less satisfactory for aflatoxins B_2 and G_2 and sterigmatocystin. However, growth conditions of the brine shrimp (including growth media, pH, temperature, and age of shrimp) and toxicity inherent in smoke condensate and condensate fractions are all variables which must be individually controlled for each specific mycotoxin. These studies indicate that the brine shrimp bioassay is a sensitive test to look for the presence or absence of mycotoxins in tobacco smoke or condensates on the basis of their biologic activity. If mycotoxins are found to be present and biologically active, further studies will be indicated to look into their role in the tobacco and health association.
Project Initiation Date: December 11, 1972.
Financial Support: ARS (12-14-100-11055(51)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Chemical Analysis of Tobacco, Tobacco Leaf Extracts, and Fractions Thereof.
Principal Investigator: D. L. Davis.
Abstract: During the period of Contract 6, there were 8,670 individual analyses completed in tobacco samples. This represents approximately 25,000 analyses when internal replications are considered. These requests were from 13 different tobacco and health personnel on a number of projects. During the first six months of Contract 8, 3,425 discrete analyses were completed. A written report of these analyses was sent to the individuals with a copy being retained in the laboratory. Lab personnel were involved in evaluation of these results. These analyses are important for the correlation of results with other phases of the program such as smoke chemistry and bioassay. In an important research aspect, several methods were revised for increased accuracy and sensitivity. The lab changed leadership during the period of this contract and several technical assistants were trained. Presently, the lab is a functional and efficient operation that provides useful data to several projects.
Project Initiation Date: July 1970.
Financial Support: ARS (12-14-100-10326(73), 12-14-100-11044(75)).

University of Kentucky, Department of Agronomy, Lexington, Kentucky 40506
Project Title: Investigations on Nitrogen Fractions in Leaf and Smoke of Low Alkaloid (LA) and Normal Burley 21 Lines.
Principal Investigator: L. P. Bush.
Abstract: Burley 21 and Low Alkaloid (LA) Burley 21 were grown in the field and sampled at 12 day intervals from transplanting to late harvest

stage. Leaf samples taken for the first six sample dates were oven-dried and analyzed for total-N, protein-N, nitrate-N, alkaloid-N, and volatile bases. Total-N, protein-N, and nitrate-N were equal in the two lines. Alkaloid-N was lower in LA Burley 21 but volatile nitrogenous bases were higher in LA Burley 21 than Burley 21. In cured leaf total-N, nitrate-N, and alkaloid-N were greater in Burley 21 than LA Burley 21. However, protein-N, volatile nitrogenous base-N, and total volatile acids were greater in LA Burley 21 than Burley 21. There was no difference in total-N or nitrate-N in green or cured stalk between the two genotypes. Alkaloid-N was lowest in LA Burley 21 stalks.
Project Initiation Date: July 1, 1972.
Financial Support: ARS (12-14-100-11041(34)).

University of Kentucky, Tobacco and Health Research Institute, Lexington, Kentucky 40506
Project Title: Preparation of Tobacco, Fabrication, Characterization, and Selection of Sample Cigarettes.
Principal Investigator: R. B. Griffith.
Abstract: The need for the fabrication of sample cigarettes from experimental tobaccos was recognized at the inception of the ARS Tobacco and Health Research effort at the University of Kentucky. Sample cigarettes have been produced from more than 140 experimental samples and these have been stored and are still available for chemicals and bioassay studies. Since the program model specifies that such services will be provided by Institute personnel, this project has been transferred to the Tobacco and Health Research Institute. The current status of the sample preparation effort will be presented.
Project Initiation Date: June 1972.
Financial Support: ARS (12-14-100-11045(75)); KTRB Core Services.

University of Kentucky, Department of Pharmacology, Lexington, Kentucky 40506
Project Title: Microbial Flora of the Airways in Normal and Smoke Inhalation Exposed Rats.
Principal Investigators: H. A. Gordon and R. F. Wiseman.
Abstract: The present study concentrated on microbial counts and on the identification of species in the airways of normal control and smoke-exposed rats (adult Holtzman and Fischer 344 males). All rats were maintained on a sterilized diet in the same air-conditioned room for at least three months, at 22-23 degrees C temperature, 50-60 percent relative humidity. Housing was in plastic, wiretop cages, two to three rats/sq ft floor space on autoclaved corn cob type bedding. No attempt was made to prevent coprophagy. In all these operations strict hygienic rules were observed. The rats exposed to smoking received three consecutive cigarettes (standard reference, high- or low-nicotine content) per day over a period of three days in our long-range smoking apparatus. The animals were unanesthetized; smoke profile was 10 percent smoke-air mixture, 10 sec. smoke inhalation, 50 sec air breathing cycles, 10 cycles per cigarette. Microbial testing of the airways was 90-120 min after the last smoking episode. Sacrifice was by decapitation, preventing seepage of blood into the airways. On autopsy surgical sterility was maintained. The chest cavity was opened and tissue samples were taken from the following areas: (1) lower portion of the right intermediate lobe; (2) apex of the right upper lobe; (3) lung tissue at the emergence of the bronchi (lung hilus); (4) bronchi; (5) trachea; (6) oropharynx; and (7) mid-portion of the nasal septum. These tissue samples taken under sterile conditions were weighed and used for making direct smears (mucosal side facing the nutrient

medium, as applicable). General medium was brain-heart infusion agar supplemented with yeast extract and hematin, in conventional sized petri dishes. Counting of colonies was 48 hrs post inoculation; incubation was at 37 degrees C. Identification of microbes grown was by gram stain (streptococci), subculturing on blood agar (hemophilus sp.), Tergitol 7 (coliforms), trypticase soy agar (for others). All microbial counts were expressed per 100 mg tissue. The results of this study indicated the following trends: (1) In nonsmoked rats the upper respiratory ways were found richly populated by a mixed flora. In the deeper passages (bronchi, lung hilus), bacterial counts were greatly reduced, reaching a near bacterium-free state in the airways of the lung parenchyma. The microbial species isolated were primarily diplococcus and staphyloccus type. (2) Acute and subacute smoke exposure profoundly changed this picture. While the numbers of bacterial in the upper respiratory passages were not particularly altered, a clear-cut bacterial penetration into the deeper airways was observed. Under these circumstances the diplococci (pneumococci) and staphylococci virtually disappeared and were essentially replaced by a hemophilus and streptococcus population. It was also indicated that more prolonged (to one month) smoke exposure further intensified the flora penetration into the deeper airways. In these details, the use of high- or low-nicotine content cigarettes (which showed no differences in their tar content) did not modify the effect of smoking on the tracheobronchial flora. Under these circumstances of smoking, no overt signs of respiratory impairment were observed in our rats.
Project Initiation Date: July 1971.
Financial Support: USDA, ARS.

Arthur D. Little, Inc., P. O. Box 1861, Boston Massachusetts 02105
Project Title: Tobacco and Health-related Research Involving Bioassay of Experimental Cigarettes.
Principal Investigators: T. C. Tso, P. S. Thayer, and S. P. Battista.
Objectives: To (1) determine and compare the biological activities of cigarette smoke made from experimental tobaccos varying in genetic background, stalk positions, and special post-harvest treatment, and (2) compare the results among various short-term bioassay systems.
Results to Date: Tests were completed evaluating 42 cigarette samples by ciliary inhibition in vitro, cell culture cytotoxicity, and inhibition of alveolar macrophage activity in vitro. In the ciliary test, the criterion for measuring the ciliotoxic effect of experimental cigarettes is based on the ability to measure the capacity of cilia to perform useful work. LN-38 appeared to be most toxic, and the NC-95 the least, especially the tobacco leaves at the top stalk position. In the cytotoxicity assay, the inhibition of growth of the KB cell line produced by the water-soluble components of smoke condensate is measured. Results show that middle stalk position leaves are more active than either the lower or the higher ones, whereas varieties showed the following sequence of increased activity: Coker-139, SC-58, NC-95, and LN-38. In the macrophage assay, the effect of cigarette smoke on the removal of bacteria by alveolar macrophage harvested from rabbit lung is measured. Leaves from lower stalk positions appeared to be less active. The varieties rank in increasing activity as follows: LN-38, NC-95, SC-58, and Coker-139, which is the reverse of the cytotoxicity test system. CRIS Progress Report (January 1970-August 1972).
Project Dates: June 23, 1971-August 1, 1972.
Financial Support: ARS, AERD (12-100-11000(34)).

Health Research Inc., 666 Elm Street, Buffalo, New York 14203.
Project Title: Preparation and Bioassay of Smoke Condensate From Experimental Cigarettes.
Principal Investigators: Fred G. Bock and T. C. Tso.
Objective: To determine the carcinogenic activity of smoke condensate from cigarettes made of experimental tobaccos with various chemical treatments.
Results to Date: The study is in a preliminary phase.
Future Plans: Results may be used to develop a less harmful tobacco.
Project Dates: June 1973-December 1975.
Financial Support: ARS (0701-10773-004-C).

Health Research, Inc., 666 Elm Street, Buffalo, New York 14203.
Project Title: Preparation and Bioassay of Smoke Condensate From Tobacco Samples.
Principal Investigators: T. C. Tso and Fred G. Bock.
Objective: To determine the carcinogenic activity of smoke condensate from tobaccos of varietal, cultural, or curing differences.
Results to Date: Dyrene acts as a tumor promoter only and is not a complete carcinogen. The threshold promoting activity of dyrene is approximately 0.1 percent. Determination of the promoting activity of extracts of various tobacco samples is also completed. Flue-cured-type tobacco, whether flue-cured or air-cured, or air-cured-type tobacco, whether air-cured or flue-cured, did not differ significantly in tumor-promoting activity. Different ways of flue curing, including open gas, open oil, and closed system exercised no effects on tumor-promoting activity. Among tobacco samples produced for various soil fungicide treatments, Telone appears to induce a higher tumor rate than vorlex or control. Among nematocides, DD showed the lowest tumor rate in comparison with soilbrom 85, Mocap, and nontreated control. All these samples were tested as promoters. CRIS Progress Report (February 1971-February 1972).
Project Dates: June 26-August 7, 1972.
Financial Support: ARS, PSRD (12-14-100-9542(34)).

American Health Foundation, 2 East End Avenue, New York, New York 10021.
Project Title: Nonvolatile Nitrosamines in Tobacco Smoke. II. Analysis of the Smoke of Different Tobacco Types and Varieties.
Principal Investigators: Dietrick Hoffman and Stephen S. Hecht.
Objective: To identify the major tobacco types that serve as precursors for the nonvolatile nitrosamines in the smoke of commercial tobacco products.
Results to Date: The study is in a preliminary phase.
Project Dates: June 1973-1975.
Financial Support: ARS (12-14-100-11031 (34) Amendment).

American Health Foundation, Division of Environmental Carcinogensis, 2 East End Avenue, New York, New York 10021.
Project Title: Volatile N-Nitrosamines in Cigarette Smoke.
Principal Investigators: Deitrick Hoffman and Stephen S. Hecht.
Objectives: To (1) determine quantitatively volatile N-nitrosamines (VNA) in the smoke of cigarettes made from leaves from various tobacco varieties and stalk positions and from various modified tobacco products; (2) identify the major precursors of previously identified VNA that are known animal carcinogens; and (3) accomplish their reduction in the smoke.
Results to Date: Tobacco smoke contains dimethylnitrosamine, methylethylnitrosamine, and diethylnitrosamine. With increasing stalk position of the tobacco leaf the yields of VNA in the smoke increases. These animal carcinogens can be reduced selectively by certain filter material.
Project Dates: January 1973-1974.
Financial Support: ARS (12-14-100-11031 (34)).

American Health Foundation, 180 East End Avenue, New York, New York 10028.
Project Title: Characteristics of Experimental Cigarettes and Smoke.
Principal Investigators: T.C. Tso and D. Hoffmann.
Objective: To determine characteristics of experimental cigarettes and cigarette smoke that are being bioassayed for tobacco-health studies.
Results to Date: Preliminary analyses are underway of cigarette samples from experimental tobacco treated with various sucker control materials. Also included in this study are samples produced in the field and treated with other pesticides. Freeze-dried tobacco delivered 50 percent less total particulate matter, nicotine, phenol, total volatile phenols and 16 percent less benz(a)anthracene and benzo(a)pyrene. CRIS Progress Report (February 1971-February 1972). Final results are subject to completion of the investigation.
Project Dates: May 18, 1970-June 14, 1973.
Financial Support: ARS, PSRD (12-14-100-10295(34)).

American Health Foundation, 180 East End Avenue, New York, New York 10028.
Project Title: N-Nitrosamines in Unaged Smoke From Experimental Cigarettes of Well-defined Flue-cured Tobacco Samples.
Principal Investigators: T. C. Tso and D. Hoffmann.
Objective: To determine volatile N-nitrosamines in unaged mainstream smoke from experimental tobaccos of well-defined characteristics designed to determine the relationship among leaf components and nitrosamine fractions.
Results to Date: Measurement of N-nitrosamines from experimental cigarettes by using the new analytical method is now underway; half the samples are com-

plete. CRIS Progress Report (June 1972-July 1973). Final results are subject to completion of the investigation.
Project Dates: May 18, 1972-August 17, 1974.
Financial Support: ARS, PSRD (12-14-100-1103 (34)).

American Health Foundation, 180 East End Avenue, New York, New York 10028.
Project Title: Physical Properties of Cigarettes and Chemical Composition of Smoke.
Principal Investigators: T. C. Tso and D. Hoffmann.
Objective: To study the relationship among leaf characteristics and smoke components.
Results to Date: The yield of hydrogen cyanide, nicotine, total particulate matter, polycyclic hydrocarbons, and volatile phenols increased significantly with increase in stalk position. The top leaf apparently contained higher concentration of precursors of these smoke constituents than the lower leaves.
CRIS Progress Report (February 1971-February 1972).
Project Dates: June 25, 1969-February 12, 1972.
Financial Support: ARS, PSRD (12-14-100-10283 (34)).

New York University Medical Center, Institute of Environmental Medicine, 550 First Avenue, New York, New York 10016.
Project Title: Cell-culture Bioassay of Tumor-promoting Activities of Tobacco Condensate and Chemicals.
Principal Investigators: A. Sivak, B. L. Van Duuren, and T. C. Tso.
Objective: To establish a short-term cell culture bioassay system for determining the tumor-promoting activity of agricultural chemicals and cigarette smoke condensates from selected varieties of experimental tobacco with special field treatments.
Results to Date: Of nine chemicals tested, three were active in the assay system. These were Dasanit (O, O-dietyhl-O-(p-(methylsulfinyl)phenyl) phosphosphorothioate), Penar (dimethyldodecylamine, acetate salt), and T-148 (a mixture of 1-octanol and 1-decanol). Six cigarette smoke condensates were examined to determine the effects of various suckering treatments. No specific treatment could be related to differences in activity in the cell culture system. Four additional cigarette smoke condensates represented two tobacco varieties (Catterton and Robinson) grown with high or low nitrogen. The Catterton tobacco grown with high nitrogen yielded the condensate with the most potent biological activity of the entire set. Thirty-two cigarette condensates were tested as part of a study relating tobacco leaf and cigarette smoke chemistry to biological activity. The condensates were derived from four different tobacco varieties and leaves obtained from eight vertical levels from the base to top of the plant. In three of the four tobacco varieties there appeared to be a general increase in tumor-promoting activity with higher leaf positions. A comparison of biological activity of chemicals and tobacco products in the cell culture system corresponded well with the activity observed in mouse skin bioassay for tumor promotion.
Project Dates: June 1970-1972.
Financial Support: ARS, PSRD (12-14-100-10320 (34)).

USDA, Agricultural Research Service, Southern Region, Tobacco Research Laboratory, Oxford, North Carolina 27565.
Project Title: Breeding, Genetics, and Pest Control of Tobacco.
Principal Investigators: James F. Chaplin, G. R. Gwynn, L. G. Burk, and A. H. Baumhover.
Objectives: To (1) develop breeding lines and varieties of tobacco with resistance to pests, and (2) produce lines with varying levels of certain chemical constituents that might be important to smoking and health.
Results to Date: Lines and varieties have been developed with resistance to root knot nematodes, black shank, Fusarium and bacterial wilt, and mosaic. Lines have been developed with extremely low nicotine content (approximately 0.2 percent total alkaloids). These lines have been used in smoking and health studies.
Project Dates: March 1973-1978.
Financial Support: USDA, ARS.

Cooperative State Research Service

North Carolina State University, Pesticide Residue Research Laboratory, 3709 Hillsborough Street, Raleigh, North Carolina 27607.
Project Title: Pesticide Residues in Tobacco, Tobacco Products, and Mainstream Smoke.
Principal Investigator: T. J. Sheets.
Objectives: To (1) determine residues of new pesticides at different stages of tobacco processing; (2) follow trends in kinds and levels of pesticides in cured tobacco and tobacco products; and (3) develop and refine methods for pesticide analysis on tobacco.
Results to Date: The efficiency of four methods of extraction of DDT and TDE residues from tobacco were studied. The most efficient extraction solvent was acetonitrile - water, followed by chloroform - methanol, benzene, and n-hexane. The results of this study have made it possible to correct data obtained from previous surveys. Linear regression equations were derived to estimate total residues of DDT and TDE in tobacco from the analysis of only a single component of each insecticide, the p,p-isomer. The regression equations are intended for quality control monitoring for these insecticides on tobacco and should shorten the time required for such analyses. Flue-cured tobacco sampled during the time of sale averaged 6.1 and 0.85 ppm for DDT + TDE in 1970 and 1972, respectively. In 1970, 30 percent of the flue-cured samples contained toxaphene residues; in 1972 over 90 percent were positive for toxaphene. Endosulfan residues on flue-cured tobacco dropped from 2.6 ppm in 1970 to 0.75 ppm in 1972. Endrin residues for 1970 and 1972 remained near the detection limit of the analytical techniques. Similar patterns in chlorinated insecticide residues were found in burley, air, and fire-cured tobaccos. Maleic hydrazide (MH) residues on flue-cured tobacco averaged 87 ppm. Other types of tobacco had slightly lower residue levels. Tobacco products were sampled from the retail market over a six-month period in 1971 and 1973. The 1971 sampling showed little change in residue levels of DDT and TDE from products sampled in 1969. In 1971 DDT + TDE residues were 41 ppm for cigarettes, 16 ppm for cigars, 22 ppm for smoking tobacco, 13 ppm for chewing tobacco, 16 ppm for snuff, and 18 ppm for little cigars. In 1973 only cigarettes showed any significant change in DDT + TDE residues. These residues dropped to an average of 12.0 ppm for 16 brands. Toxaphene

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residues on all types of tobacco products were lower in 1973 compared with 1971. Cigarettes showed the greatest drop in toxaphene residues from 3.3 ppm in 1971 to 1.4 ppm in 1973. Endrin values were higher in chewing tobacco than in the other products in both 1969 and 1972 (0.14 and 0.10 ppm, respectively). Endosulfan residues were generally low; cigarettes had the greatest value (0.8 ppm). The effect of freeze-drying techniques on the reduction of insecticide residues on tobacco were studied. Total DDT and TDE residues were reduced by 10-42 percent and total endosulfan residues were reduced by 34-43 percent. The disappearance of parathion applied to tobacco was studied in replicated field plot experiments conducted at three locations. Mean residues for green tobacco sampled immediately after application of 0.5 lb/A ranged from 47.5 to 54.6 ppm and 0.65 to 0.7 ppm, respectively, for parathion and paraoxon. The loss of parathion from the leaves was over 95 percent in five days and greater than 99 percent at nine days after application. Maximum levels of paraoxon occurred one day after application, and at the 0.5 lb/A rate averaged 1.36 ppm. Flue curing caused approximately 70 percent loss of parathion. The residue of monocrotophos (Azodrin) applied to tobacco at a rate of 0.5 lb/A averaged, over three locations, 41 ppm at time zero. The residue after five days and 9 days was 9 and 3 ppm, respectively. Flue curing reduced the residue by more than 99 percent.

Project Dates: December 1969-1974.
Financial Support: North Carolina State University; CSRS; Tobacco Industry (six companies).

U.S. Department of Defense

U.S. Air Force, School of Aerospace Medicine, Cardiopulmonary Section, Brooks Air Force Base, Texas 78235
Project Title: Correlation of Serial ECG Changes and/or Abnormal ECG Responses to Treadmill Testing With Coronary Artery Disease.
Principal Investigator: Victor F. Froelicher
Objective: To determine the value of exercise testing and serial electrocardiograms (ECG) in detecting silent coronary artery disease.
Results to Date: About 50 percent correlation of abnormal ECG studies with angiographic or symptomatic disease has been observed. Lower risk ratio, sensitivity, and specificity than previously reported has also been seen, suggesting that primary prevention is more important than screening and secondary prevention.
Future Plans: Men previously seen in 1965-1968 and angiographed more recently will be evaluated annually.
Project Dates: July 1972-continuing.
Financial Support: U.S. Air Force.

U.S. Air Force, School of Aerospace Medicine, Clinical Sciences Division, Brooks Air Force Base, Texas 78235
Project Title: U.S. Air Force School of Aerospace Medicine Cardiovascular Disease Follow-up Study.
Principal Investigators: Margaret Allen, Dale A. Clark, and Malcolm Lancaster
Objectives: To collect information about the relationship of serum lipid and lipoprotein levels in young men with subsequent occurrence of symptoms of cardiovascular disease; and evaluate serum lipid and lipoprotein levels as parameters to be used in screening applicants for training for certain Air Force career fields.
Results to Date: Serum lipid and low-density lipoprotein mean levels increased markedly during the first six years of the study to a maximum cholesterol mean level of 249 mg/100 ml in 1958, when the mean age was 25.5 years. Since that year, the means for those serum components have declined slightly for two to four years, and then resumed a trend of slowly increasing values. The high-density lipoproteins declined during the early years when the low-density lipoproteins were increasing, but have increased since the lowest levels of 1958. Paucity of clinical symptoms of cardiovascular disease precludes correlation of the lipid data with the occurrence of disease at this time, but the lipid data are available for eventual correlation with disease.
Future Plans: Collection of lipid and lipoprotein data and of ECG's, results of medical examinations, and pertinent health data will continue throughout the life of the subjects. If possible, each subject will also receive a thorough medical examination designed to evaluate the cardiovascular system.
Project Dates: June 1952-continuing.
Financial Support: USAF, Aerospace Medical Division

U.S. Naval Aerospace Medical Institute, Medical Research Laboratory, Naval Aerospace and Regional Medical Center, Pensacola, Florida 32512
Project Title: Longitudinal Follow-up Study of the Physical Status of 1,000 Naval Aviators.
Principal Investigators: R.E. Mitchell and A. Graybiel
Objectives: To provide data from the study of 1,000 aviators to establish more realistic physical standards for aviation, and provide methods of early prediction of alterable or preventable conditions, with the ultimate goal

of extending the useful life to the naval aviator.
Results to Date: The men who remained on active duty after World War II have been healthier for the most part than those who left the service after the war. There are fewer who have high blood pressure, heart disease, and psychiatric disease. They do have, as might be expected, more hearing loss. Urinary tract disease has been more prevalent, and they have had a greater number of surgical procedures. Specific areas of interest have been blood pressures and electrocardiograms. Blood pressures have not increased with age in every individual; in fact, in the majority of the men there was a random variation in blood pressure during the first 24 years of follow-up. The increase noted was the result of a consistent rise in pressure experienced by a small number of individuals. The findings in the 1969-1972 follow-up are of significance in that they indicate that some of the members of the group are showing accelerated severe changes in blood pressure patterns. The electrocardiographic findings have been of significance. Ninety of the men were taken into flight training with electrocardiographic findings that would be considered as frank or borderline abnormalities today. By 1951, 59 of these records had reverted to normal and of those with persistence of abnormalities none had developed clinically apparent heart disease up to the time of the 1964-1965 examinations. There have been longitudinal changes in the resting electrocardiograms that may ultimately prove to be of value as predictors of disease.
Project Dates: June 1940-continuing.
Financial Support: U.S. Navy Bureau of Medicine and Surgery

U.S. Environmental Protection Agency

University of California, Irvine, Department of Community and Environmental Medicine, Irvine, California 92664
Project Title: Exposure of Tissue Culture Systems to Air Pollutants Under Conditions Simulating Physiologic States of Lung and Conjunctiva.
Principal Investigators: T. Timothy Crocker and B. K. Nair.
Objective: To develop an in vitro system to test toxic, mutagenic, and neoplastic effects of gaseous and particulate air pollutants in a situation simulating that of the respiratory tract and conjunctiva, which are targets for the action of pollutants.
Results to Date: A technique for isolating and culturing tracheal epithelial cells has been developed. These cells should be available in plenty for experimental uses in the near future. Hamster embryo cells are prepared and their normal growth pattern, cloning efficiency, and clonal morphology have been studied. This will function as base-line observations for future work. The maximum period of time cells can be exposed outside the medium for exposure to pollutants and the effect of a moving fluid meniscus on clones and monolayers have been determined.
Project Dates: March 1973-February 1975.
Financial Support: EPA (68-02-1204)

University of Southern California, School of Medicine, 2025 Zonal Avenue, Los Angeles, California 90033
Project Title: Effects of Fresh Cigarette Smoke Inhalation on the Respiratory Tract of S.P.F. Mice.
Principal Investigators: Clayton G. Loosli and Helgard Niewisch
Objective: To compare lung changes in S.P.F. mice subjected daily, five days

per week, to fresh cigarette smoke inhalation over several months' time with those of control (nonexposed) mice.
Results to Date: Different strains of mice have been exposed for 5-9 months and were approximately eight weeks of age at the start of the study. The mice lose some weight during the five-day smoking period but regain it over the weekend. No increase in pulmonary adenomas occurred in the smoke-exposed groups compared with controls. Lung changes consist of (a) bronchial epithelial cell hyperplasia, and (b) focal collections of leukocytes and pigment-filled macrophages in alveoli in the regions of the terminal bronchioles. The focal macrophage pneumonitis persisted in the lungs of mice sacrificed four weeks after smoke exposure was discontinued. Mice exposed to fresh cigarette smoke for nine months showed no changes characteristic of emphysema.
Project Dates: July 1972-June 1974.
Financial Support: Hastings Foundation Fund; Howard Hughes Employees Give Once Club: EPA (APO1075-03); Council for Tobacco Research, U.S.

Stanford Research Institute, 333 Ravenswood Avenue, Menlo Park, California 94025.
Project Title: Chronic Obstructive Lung Disease. Ultrastructure and Cytochemistry of NO_2- and O_3- Exposed Rat Lungs.
Principal Investigator: Robert J. Stephens
Objective: To examine ultrastructurally and cytochemically lungs exposed both continuously and intermittently to nitrogen dioxide (NO_2) and/or ozone (O_3) for various periods of time from one hour to several months and to compare the cellular response of these to that induced by cigarette smoke.
Results to Date: The emphasis of the study has been on ozone and nitrogen dioxide exposure. To date, it has been found that the biological and cellular response of lung tissue is about equal when animals are exposed to approximately 0.5 ppm O_3 or 15 ppm NO_2. These exposure levels are characterized by significant cellular injury and destruction, especially in the terminal bronchioles and proximal alveoli. The nonciliated cells of the airways and type 2 cells of the parenchymal tissue are resistant to injury and act as stem cells for the replacement of the more sensitive ciliated and type 1 cells. Whole cigarette smoke causes a similar reaction when animals are first exposed to it.
Project Dates: September 1972-1977
Financial Support: EPA (ES 0084-02)

National Academy of Sciences - National Research Council, Medical Follow-up Agency, 2101 Constitution Avenue NW, Washington, D.C. 20418 and Karolinska Institute, Stockholm, Sweden.
Project Title: Respiratory Symptoms in Twins in Relation to Residence-associated Air Pollution, Tobacco and Alcohol Use, and Other Factors.
Principal Investigators: Zdenek Hrubec, Rune Cederlof, and Lars Friberg.
Objective: To examine the effect of residence-associated long-term exposure to air pollution and its interaction with other potential factors in chronic respiratory disease.
Results to Date: Among individuals, respiratory symptoms were found to be related to urban residence, tobacco smoking, alcohol use, and socioeconomic status. Among individuals, smoking appeared to be the variable most closely related to respiratory symptoms when the effect of other factors had been controlled. In pairs of twins who differed on air pollution exposure but who had a comparable smoking experience, no significant difference in the

rate of respiratory symptoms could be demonstrated between those with less and those with more exposure to air pollution.
Project Dates: June 1971-1973.
Financial Support: EPA (68-02-0089)

EPA, Human Studies Laboratory, National Environmental Research Center, Research Triangle Park, North Carolina 27711.
Project Title: Chronic Respiratory Disease: Determinants of Symptom Prevalence In Adults.
Principal Investigators: Douglas I. Hammer and Carl G. Hayes.
Objectives: To describe and summarize the prevalence of chronic respiratory disease symptoms in relation to age, sex, race, cigarette smoking, history of occupational exposure, education, and history of asthma, heart, or lung disease and exposure to various types of ambient air pollutants among parents of elementary schoolchildren.
Results to Date: Smoking prevalence was higher in males, in persons with any occupational exposure, and in persons with less than a high school education. CRD is 7-10 times higher among one pack a day smokers than among nonsmokers. Increased CRD is also associated with a history of occupational exposure, a history of asthma, heart, or lung disease, and to a lesser extent, with increasing age (but only about 10 percent of the study populations are 50 or more years of age). After appropriate adjustment, CRD rates among persons in high sulfur oxide exposure communities were greater than the rates for comparable groups in low-exposure communities.
Project Dates: October 1970-1975.
Financial Support: EPA.

EPA, Human Studies Laboratory, National Environmental Research Center, Research Triangle Park, North Carolina 27711
Project Title: Cigarette Smoke: Effects Upon Nonsmoking Adults and Children.
Principal Investigators: Douglas I. Hammer and Carl G. Hayes
Objective: To determine the risk of respiratory illness or symptoms among adult and child nonsmokers exposed to cigarette smoke.
Results to Date: Preliminary analyses of smoking-discordant parents have not shown higher chronic respiratory disease symptom prevalence among nonsmokers with smoking spouses. Factors such as smoking intensity and duration of exposure to sidestream smoke have not yet been analyzed. Preliminary analyses of the frequency of acute lower respiratory diseases among children of smoking parents have yielded inconsistent results. Analyses of the prospective acute respiratory disease studies have suggested that, in those families where one or both parents smoked cigarettes, children had a significantly higher rate of acute respiratory diseases when compared with children in nonsmoking families. All of these results will require further analysis to reach any final conclusion.
Project Dates: October 1970-1975.
Financial Support: EPA.

EPA, Human Studies Laboratory, National Environmental Research Center, Research Triangle Park, North Carolina 27711.
Project Title: Cigarette Smoking and Body Metal Burdens.
Principal Investigators: Douglas I. Hammer and Edythalena A. Tompkins.
Objective: To determine trace metal concentrations in sets of human autopsy

tissues with respect to age, sex, race, smoking habits, pathologic diagnoses, and geographic variation.
Results to Date: Estimated cadmium body burdens in adult, male, cigarette smokers were more than twice those of comparable nonsmokers. Comparisons of lead tissue levels among smokers and nonsmokers were precluded by smaller sample sizes as tissue lead tended to increase with age, a confounding variable.
Project Dates: Juen 1970-1975.
Financial Support: EPA.

EPA, Human Studies Laboratory, NERC, Research Triangle Park, North Carolina 27711.
Project Title: Chronic Respiratory Disease Symptom Prevalence Studies.
Principal Investigators: Carl G. Hayes, Dennis House, and Warren Galke.
Objectives: To (1) determine whether the prevalence of chronic respiratory disease symptoms, adjusted for age, sex, smoking, and social class, corresponds to an area gradient in air pollution; and (2) determine whether this gradient exists for each pollutant gradient within the Community Health and Environmental Surveillance System (CHESS) program.
Results to Date: Preliminary findings show individual cigarette smoking to be the overwhelming factor in chronic respiratory disease symptom prevalence. Even after adjusting for smoking, a smaller, consistent area effect does occur.
Project Dates: January 1971-1974.
Financial Support: EPA

University of Pittsburgh, Pittsburgh, Pennsylvania 15261 and Johns Hopkins University, School of Public Health, Baltimore, Maryland 21205
Project Title: Relationship Between Ambient Carbon Monoxide Exposure, Myocardial Infarct, and Sudden Death.
Principal Investigators: Lewis H. Kuller and Edward Radford.
Objective: To determine whether ambient CO levels in a large urban area are an important precipitant of sudden cardiac death and myocardial infarction.
Results to Date: This study does not support the hypothesis that ambient CO level in an urban area is a major factor in the onset of sudden death and myocardial infarction. The level of ambient CO may have been too low in Baltimore to have any effect. Another reason may have been that the major source of carbon monoxide is microenvironmental sources or personal exposure from cigarette smoking rather than from general ambient CO exposure. Cigarette smokers are generally above ambient carbon monoxide levels and are therefore expending carbon monoxide into the air. The risk of sudden death is much higher among smokers than nonsmokers. Thus the highest risk group may not be adversely affected by community ambient carbon monoxide levels. This study did not attempt to determine the importance of either cigarette smoking or microenvironmental exposure to carbon monoxide as possible precipitants of sudden death and myocardial infarction. However, a substantially higher percentage of ASHD sudden deaths were heavy cigarette smokers compared with age, race and sex, and neighborhood matched controls. Other possible reasons include a long lag period between CO exposure and onset of myocardial infarction.
Project Dates: June 1971 - 1974.
Financial Support: EPA (68-02-0082); Coordinating Research Council, Inc.

U.S. Veterans Administration

Yale University, School of Medicine, 155 Whitney Avenue, New Haven, Connecticut 06510.
Project Title: Improvement of Methodology for Clinical Evaluations.
Principal Investigators: Alvan R. Feinstein, Walter A. Ramshaw, and Moreson H. Kaplan.
Objective: To determine critical features ("landmarks") of patients with chronic disease in order to estimate prognosis and evaluate therapy.
Results to Date: In preliminary studies of medical record date for patients with cancers of the lung, rectum, and larynx, the feasibility, practicality, and value of these new approaches have been demonstrated. The relationship of cigarette smoking and the histopathology of lung cancer has been evaluated.
Financial Support: NCHSRD (HS00408); U.S. Veterans Administration.

Yale University, School of Medicine, New Haven, Connecticut 06510 and U.S. Veterans Adminstration Hospital, West Haven, Connecticut 06516.
Project Title: Infection in Chronic Bronchitis and Emphysema.
Principal Investigator: Robert H. Green
Objective: To assess the role of various environmental factors, especially infectious agents such as viruses and mycoplasmas, in the etiology and pathogenesis of chronic bronchitis and emphysema.
Results to Date: The study is in the initial stages of data tabulation.
Project Dates: June 1967-1974
Financial Support: NIAID (AI 08418); U.S. Veterans Administration.

U.S. Veterans Administration Hospital, Outpatient Clinic, Normative Aging Study, 17 Court Street, Boston, Massachusetts 02108.
Project Title: Smoking Research in the Normative Aging Study.
Principal Investigator: Benjamin Bell
Objective: To improve the smoking research data in the Normative Aging Study so that the extensive cross sectional and longitudinal data banks of the larger study can be exploited in investigating the effects of smoking on health.
Project Dates: July 1972-continuing.
Financial Support: U.S. Veterans Administration; Council for Tobacco Research, U.S.

University of Missouri, Medical Center, Columbia, Missouri 65201
Project Title: Comparison of Damage to Airway Cells by Gas and Particle Phases of Cigarette Smoke.
Principal Investigators: Kaye H. Kilburn, Arnold R. Hudson, and Sharon C. Northup.
Objectives: To determine (1) whether particles are essential to recruit polymorphonuclear (PMN) leukocytes to airway lumens; (2) whether recruitment of leukocytes to airway lumens is protective to the epithelium; and (3) which chemical component of the particulate phase of cigarette smoke or tobacco is responsible for PMN leukocyte recruitment and identify it chemically.
Results to Date: Gas-phase smoke damages epithelial cells, causing nuclear extrusion and exfoliation of cells. Whole smoke in contrast recruits leukocytes as does the particle phase alone. Gas phase effects resemble those

produced by 15 ppm of nitrogen dioxide.
Project Dates: November 1971-1977.
Financial Support: U.S. Veterans Administration; Cotton Incorporated.

U.S. Veterans Administration Hospital, Tremont Avenue at South Center Street, East Orange, New Jersey 07019 and Waldemar Medical Research Foundation, Woodbury, New York 11797.
Project Title: Criteria For Detection of Asymptomatic Oral Carcinoma.
Principal Investigators: Arthur Mashberg and Daniel Roth
Objectives: To (1) Clarify existing criteria and evaluate newly developed techniques for recognizing early malignancy in the oral cavity, and (2) correlate alcoholism, liver disease, and smoking with malignancy or precancerous lesions of the oral cavity.
Results to Date: The study is in a preliminary phase.
Project Dates: 1973-1975.
Financial Support: U.S. Veterans Administration.

U.S. Veterans Administration Hospital, Irving and University Streets, Syracuse, New York 13210
Project Title: Studies of Endogenous Carbon Monoxide Production
Principal Investigator: Stephen Arthur Landaw
Objectives: To (1) study heme kinetics through the use of ^{14}C-labeled CO production; (2) study red blood cell destruction in newborn infants through CO production; and (3) evaluate CO body burdens in smokers, with special reference to induced erythrocytosis, altered plasma volume, etc.
Project Dates: July 1973 - continuing.
Financial Support: NHLI (5K4 HL17693-03); AEC and NASA (W7405-eng-48); AMA-ERF; U.S. Veterans Administration.

U.S. Veterans Administration Center, Temple, Texas 76501
Project Title: Evaluation of Nitrogen Washout Curve as Clinical Pulmonary Function Test.
Principal Investigator: Robert G. Rossing.
Objectives: To (1) evaluate the nitrogen washout curve as an early indicator of minimal obstructive lung disease, and (2) compare several different indices that had been proposed for evaluation of such curves.
Results to Date: There is no discernible difference between the group means for the nonsmokers and the young smokers. The group mean value for several indices was somewhat higher in the group with the longer smoking history but the inter- and intrapersonal variation in all subject groups was such that the differences were not statistically significant. This variability also makes it unlikely that the test will be useful as a screening procedure. Correlation coefficients were calculated between the various indices and they were found to be very high, indicating that the indices are all probably measuring the same parameter and that the information content of each is essentially identical.
Project Dates: July 1971 - 1973.
Financial Support: U.S. Veterans Administration

U.S. Veterans Administration Center, Temple, Texas 76501
Project Title: Instantaneous Ventilatory Turnover Rate During the Forced Vital Capacity (FVC) Maneuver.

Principal Investigators: Robert C. Rossing, R.D. Allison, And S. Rao
Objectives: To (1) evaluate the turnover rate (TR) of at least 200 asymptomatic subjects at various lung volumes as a possible screening procedure for early obstructive dysfunction; (2) determine normal limits; and (3) determine the effects of age, sex, and smoking on these limits.
Results to Date: The study is in a preliminary phase.
Project Dates: November 1973 - 1974
Financial Support: U.S. Veterans Administration.

U.S. Veterans Administration Center, Hampton, Virginia 23667
Project Title: Effects of Alcohol and Tobacco on Human Mucosa.
Prinicpal Investigator: Henry J. Kalwaic.
Objective: To identify a possible early cytologic or histologic sign before clinically evident changes take place in the human oral mucosa.
Results to Date: To date, 49 volunteers have been interviewed and scraped, and a small piece of buccal mucosa has been excised under local anesthesia. Although a complete correlation has not yet been accomplished, some deviations from normal histology and cytology have been noted in the microscopic examination. However, no definitive conclusions have been attempted.
Future Plans: Gathering of data will continue on a random basis until a total of about 100 patients is reached. Questionnaires will be classified into the four groups (with subgroups if required). The patient total will be selectively amplified if necessary to obtain reasonably equal distribution.
Project Dates: July 1972-1974.
Financial Support: U.S. Veterans Administration.

U.S. Veterans Administration Hospital, North 4815 Assembly, Spokane, Washington 99208.
Project Title: Effects of Snuff Usage on the Oral Mucosa.
Principal Investigator: Robert P. Campbell
Objectives: To determine (1) the exact histopathological nature of the mucosal lesion produced by snuff; (2) any carcinogenic effects resulting from the use of this form of tobacco; (3) any correlation between the concomitant use of alcohol with tobacco in the production or nature of the lesions; and (4) the reversibility of the lesions following a period of abstinence from snuff.
Results to Date: Over 100 cases have been documented. Microscopic examination of tissue specimens has shown varying degrees of hyperkeratosis, parakeratosis, acanthosis, and submucosal chronic inflammatory infiltrates. No malignant cells have been found in any case. No apparent correlation has been shown between the concomitant alcohol and tobacco use and the clinical or microscopic appearance of the lesions. The lesions have been found to be reversible in whole or in part depending on the severity of the lesion at the time of abandonment of tobacco.
Project Dates: October 1968-1974
Financial Support: U.S. Veterans Administration.

Mr. NATCHER. Thank you, Mr. Chairman.
Mr. FLOOD. Mr. Shriver.

PRESIDENT'S BIOMEDICAL RESEARCH PANEL

Mr. SHRIVER. Thank you, Mr. Chairman.

On page 12 of your statement you mention the President's biomedical research panel which has been established to review and make recommendations. Just what is expected out of that?

Dr. COOPER. The requirement for the biomedical research panel is found in the extension of the cancer legislation. That was May 1974. And that panel is composed of seven members, one of which is by statute the chairman of the cancer panel, which is also mandated in that law.

It includes one other layman and five physicians. I will be happy to provide their specific names if that is of interest to you.

Mr. SHRIVER. No.

Dr. COOPER. In that law the requirement is for them to review and assess the research needs and the programs of the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration with the view toward determining whether or not there are different kinds of organizational or management needs or how they should be done and how they should be funded. These are specified in that particular piece of legislation.

It directs that the study be done in 15 months and then reported to the Congress and to the President.

Mr. SHRIVER. And the 15 months will be over when?

Dr. COOPER. We should have it by next May, I believe.

BIRTH RATE

Mr. SHRIVER. There was quite a little discussion earlier about the position of this country in connection with the decline in births and how we stand healthwise. We are not in very good position relative to those that you named. Is it because we are not spending enough money as a government?

Dr. COOPER. No. I think there are several factors which contribute to our position in these particular indices, the ones that are mentioned. We are a large heterogeneous population. Some of the countries that are reported with better statistics are a more homogeneous, smaller group with a more uniform genetic background, with more uniform economic problems, more uniform geographical exposure, and indeed a different kind of lifestyle. I think you will find that our performance on these particular indices is not only a manifestation of spending money on medical care.

Now, in some instances in this country it is my belief that the lack of access to care is an important feature, and that does cost money. It involves at least the redistribution of funds. In our proposals we seek to address that within the limits that we have already proposed.

The second is that in certain groups the access to care is not followed through by the people themselves because of their lack of involvement or understanding of what that opportunity or need is.

I think there are a variety of features and I would not try to convince you or simplify it as simply a matter of dollars.

Community Mental Health Centers

Mr. Shriver. You refer to community mental health centers as a demonstration program. Was that in the law? Was that discussed in the Congress, or was this interpretation made by the Department?

Dr. Cooper. The administration interprets the law that this was intended to be a demonstration project which was successful, we might say, in its execution. Therefore we would have hoped that both the model would be adopted in the broader distribution, and in the areas in which it was started and maintained for the prescribed 8-year period, that these could become self-sufficient in preparing for the time when a broader program of financing like national health insurance, might allow it to remain competitive and an active alternative for care within a local system. But that is an administration interpretation.

Mr. Shriver. I don't recall that that is the attitude of a lot of Members of Congress on the substantive committee.

Dr. Cooper. I understand that, yes, sir.

Mr. Shriver. The chairman of the health subcommittee and others.

Dr. Cooper. I recognize this is not a uniformly accepted interpretation.

Mr. Shriver. The administration has stated in the past that there are some 150 mental health centers in existence which receive no Federal support. I wonder for the record if you could identify those.

[The information follows:]

It should be noted that the facilities included in this list differ in many respects from the traditional CMHC. They do not serve a geographically defined catchment area and are not bound to serve persons regardless of age, diagnostic category, or ability to pay and are not accountable for continuity of care.

Community Mental Health Centers Receiving No Federal Funds

Desert Samaritan Hospital,
1400 South Dobson Rd.,
Mesa, Ariz.

Arizona State Hospital,
2500 East Van Buren St.,
Phoenix, Ariz.

Good Samaritan Hospital,
1033 East McDowell Rd.,
Phoenix, Ariz.

St. Josephs Hospital,
350 West Thomas Rd.,
Phoenix, Ariz.

Sierra View Mental Health Services,
366 Elm Ave.,
Auburn, Calif.

Department of Mental Health Services,
1960 Flower St.,
Bakersfield, Calif.

Butte County Mental Health Services,
564 Rio Linda Ave.,
Chico, Calif.

Southwood Mental Health Center,
950 Third Ave.,
Chula Vista, Calif.

Del Norte Community Mental Health Services,
Infirmary Rd.,
Crescent City, Calif.

Humboldt County Community Mental Health Services,
2200 Harrison Ave.,
Eureka, Calif.
Department of Mental Health,
4441 East Kings Canyon Rd.,
Fresno, Calif.
Rancho Pino,
13133 Julian Ave.,
Lakeside, Calif.
Long Beach Neuropsychiatric Institute,
6060 Paramount Blvd.,
Long Beach, Calif.
Thalians Community Mental Health Center,
Cedars-Sinai Medical Center,
8730 Alden Dr.,
Los Angeles, Calif.
University of California at Los Angeles,
Neuropsychiatric Institute,
760 Westwood Plaza,
Los Angeles, Calif.
Contra Costa County Medical Services,
2500 Alhambra Ave.,
Martinez, Calif.
Mental Health Services for Merced County,
480 East 13th St.,
Merced, Calif.
Alameda County Health Care Services—Mental Health Division,
499 Fifth St.,
Oakland, Calif.
Tehama County Mental Health Services,
1860 Walnut St.,
Red Bluff, Calif.
Shasta County Mental Health Services,
2630 Hospital Ln.,
Redding, Calif.
Riverside County Dept. of Public Health,
Division of Mental Health Services,
3604 Ninth St.,
Riverside, Calif.
San Bernardino County Mental Health Services,
700 East Gilbert St.,
San Bernardino, Calif.
Mercy Hospital and Medical Center,
4077 Fifth Ave.,
San Diego, Calif.
San Diego County Mental Health Services,
345 West Dickinson St.,
San Diego, Calif.
St. Mary's Hospital and Medical Center,
McAuley Neuropsychiatric Institute,
2200 Hayes St.,
San Francisco, Calif.
Langley Porter Neuropsychiatric Institute,
401 Parnassus Ave.,
San Francisco, Calif.
County of Santa Cruz Community Mental Health Services,
1060 Emeline Ave.,
Santa Cruz, Calif.
Stanford University Hospital,
Stanford, Calif.
Los Angeles County Harbor General Hospital,
1000 West Carson St.,
Torrance, Calif.

Mendocino County Mental Health Services,
860–A North Bush St.,
Ukiah, Calif.
Glenn County Mental Health Services,
1133 West Sycamore St.,
Willows, Calif.
Siskiyou Mental Health Services,
804 South Main St.,
Yreka, Calif.
Sutter-Yuba Mental Health Services,
2290 Forrest Ln.,
Yuba City, Calif.
Colorado Psychiatric Hospital,
4200 East Ninth Ave.,
Denver, Colo.
Colorado State Hospital,
1600 West 24th St.
Pueblo, Colo.
Griffin Hospital,
130 Division St.,
Derby, Conn.
Hartford Hospital,
80 Seymour St.,
Hartford, Conn.
University of Connecticut Hospital,
McCook Division,
Two Holcomb St.,
Hartford, Conn.
Child and Family Services of Connecticut,
1680 Albany Ave.,
Hartford, Conn.
Undercliff Mental Health Center,
Undercliff Rd.,
Meriden, Conn.
The New Britain General Hospital,
100 Grand St.,
New Britain, Conn.
Connecticut Mental Health Center,
P.O. Box 1842,
New Haven, Conn.
Norwalk Hospital,
24 Stevens St.,
Norwalk, Conn.
The Wheeler Affiliates, Inc.
91 Northwest Drive,
Plainville, Conn.
Hall Brooke Hospital,
Division of Hall-Brooke Foundation, Inc.,
47 Long Lots Rd.,
Westport, Conn.
Wilmington Medical Center,
501 West 14th St.,
Wilmington, Del.
St. Elizabeth's Hospital,
Martin Luther King, Jr. Ave., SE.,
Washington, D.C.
Shands Teaching Hospital and Clinic,
University of Florida,
Archer Rd.,
Gainesville, Fla.
St. Vincent's Medical Center,
Barrs St. and St. John's Ave.,
Jacksonville, Fla.

Jackson Memorial Hospital,
1700 Northwest Tenth Ave.,
Miami, Fla.
Georgia Mental Health Institute,
1256 Briarcliffe Rd., NE.,
Atlanta, Ga.
Grady Memorial Hospital,
80 Butler St., SE.,
Atlanta, Ga.
Eugene Talmadge Memorial Hospital,
1120 15th St.,
Augusta, Ga.
Broad Oaks Hospital,
5002 Waters Ave.,
Savannah, Ga.
Queen's Medical Center,
1301 Punchbowl St.,
Honolulu, Hawaii.
Central Comprehensive Mental Health Center, Inc.,
1207 East Broadway,
Centralia, Ill.
Illinois State Psychiatric Institute,
1601 West Taylor St.,
Chicago, Ill.
Chicago-Read Mental Health Center.
6500 West Irving Park Rd.,
Chicago, Ill.
Children's Memorial Hospital,
2300 Children's Plaza,
Chicago, Ill.
Michael Reese Hospital Psychiatric and Psychosomatic Institute,
2959 South Cottage Grove Ave.,
Chicago, Ill.
Mount Sinai Hospital Medical Center,
2755 West 15th St.,
Chicago, Ill.
Rush Presbyterian-St. Lukes Medical Center,
1753 West Congress Parkway,
Chicago, Ill.
St. Joseph Hospital,
2900 North Lake Shore Dr.,
Chicago, Ill.
University of Chicago Hospitals and Clinics,
950 East 59th St.,
Chicago, Ill.
Northwestern University Institute of Psychiatry,
303 East Chicago Ave.,
Chicago, Ill.
Forest Hospital,
555 Wilson Lane,
Des Plaines, Ill.
Evanston Hospital,
2650 Ridge Ave.,
Evanston, Ill.
John J. Madden Zone Center,
1200 South First Ave.,
Hines, Ill.
George A. Zeller Zone Center,
5407 North University St.,
Peoria, Ill.
H. Douglas Singer Zone Center,
4402 North Main St.,
Rockford, Ill.

Larue D. Carter Memorial Hospital,
1315 West Tenth St.,
Indianapolis, Ind.
Howard Community Hospital,
3500 South La Fountain St.,
Kokomo, Ind.
Madison State Hospital,
Cragmont St.,
Madison, Ind.
Mental Health Institute,
1200 West Cedar St.,
Cherokee, Iowa
State Psychopathic Hospital,
500 Newton Rd.,
Iowa City, Iowa
University Hospital,
800 Rose St.,
Lexington, Ky.
Norton-Children's Hospital, Inc.,
200 East Chestnut St.,
Louisville, Ky.
Bath-Brunswick Area Mental Health Center,
764 High St.,
Bath, Me.
Henry Phipps Psychiatric Clinic,
The Johns Hopkins Hospital,
601 North Broadway,
Baltimore, Md.
St. Josephs Hospital,
7620 York Rd.,
Baltimore, Md.
Clifton T. Perkins State Hospital,
509 Cathedral St.,
Jessup, Md.
The Sheppard and Enoch Pratt Hospital,
P.O. Box 6815,
Towson, Md.
Human Resource Institute of Boston,
227 Babcock St.,
Brookline, Mass.
Glenside Hospital, Inc.,
49 Robinwood Ave.,
Jamaica Plain, Mass.
Salem Hospital,
81 Highland Ave.,
Salem, Mass.
Taunton State Hospital,
60 Hodges Ave. Extended,
Taunton, Mass.
Worcester State Hospital,
305 Belmont St.,
Worcester, Mass.
University Hospital Medical Center,
1405 East Ann St.,
Ann Arbor, Mich.
Thumb Treatment Assistance Center,
P.O. Box 153,
Caro, Mich.
Sinai Hospital of Detroit,
6767 West Outer Dr.,
Detroit, Mich.
Young Adult Institute,
1151 Taylor Ave.,
Detroit, Mich.

Lafayette Clinic,
951 East Lafayette St.,
Detroit, Mich.
Genesee County Community Mental Health Services,
420 West Fifth Ave.,
Flint, Mich.
Community Mental Health Services of Ottawa County,
549 West 18th St.,
Holland, Mich.
Kalamazoo State Hospital,
1312 Oakland Dr.,
Kalamazoo, Mich.
Northview State Hospital,
41001 Seven Mile Rd.,
Northville, Mich.
Brainerd State Hospital,
Brainerd, Minn.
Hennepin County General Hospital,
Fifth and Portland Sts.,
Minneapolis, Minn.
University of Minnesota Hospitals,
412 Union St., SE.,
Minneapolis, Minn.
St. Louis County Hospital,
601 South Brentwood Blvd.,
Clayton, Mo.
Mid-Missouri Mental Health Center,
803 Stadium Rd.,
Columbia, Mo.
Western Missouri Mental Health Center,
600 East 22d St.,
Kansas City, Mo.
St. Louis State Hospital Complex,
5400 Arsenal St.,
St. Louis, Mo.
Malcolm Bliss Mental Health Center,
1420 Grattan St.,
St. Louis, Mo.
St. Louis University Hospitals,
1325 South Grand Blvd.,
St. Louis, Mo.
Jewish Hospital of St. Louis,
216 South Kings Highway Blvd.,
St. Louis, Mo.
Hastings Regional Center,
Hastings, Nebr.
Camden County Psychiatric Hospital,
Blackwood Post Office,
Lakeland, N.J.
Morristown Memorial Hospital,
100 Madison Ave.,
Morristown, N.J.
Jersey Shore Medical Center,
Fitkin Hospital,
1945 Corlies Ave.,
Neptune, N.J.
Bergen Pines County Hospital,
East Ridgewood Ave.,
Paramus, N.J.
Medical Center at Princeton,
253 Witherspoon St.,
Princeton, N.J.
Riverview Hospital,
35 Union St.,
Red Bank, N.J.

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Queens Children's Hospital,
74–03 Commonwealth Blvd.,
Bellerose, N.Y.
Binghamton State Hospital,
425 Robinson St.,
Binghamton, N.Y.
Bronx State Hospital,
1500 Waters Pl.,
Bronx, N.Y.
Bronx-Lebanon Hospital Center,
1285 Fulton Ave.,
Bronx, N.Y.
Bronx Municipal Hospital Center,
Albert Einstein College of Medicine,
Pelham Pkwy. So. and Eastchester Rd.,
Bronx, N.Y.
Montefiore Hospital and Medical Center,
111 East 210th St.,
Bronx, N.Y.
Brooklyn State Hospital,
681 Clarkson Ave.,
Brooklyn, N.Y.
Edward J. Meyer Memorial Hospital,
462 Grider St.,
Buffalo, N.Y.
Central Islip State Hospital,
Carleton Ave.,
Central Islip, N.Y.
Nassau County Medical Center,
2201 Hempstead Turnpike,
East Meadow, N.Y.
Long Island Jewish-Hillside Medical Center, Hillside Div.,
75–59 263d St.,
Glen Oaks, N.Y.
St. Vincent's Hospital and Medical Center of New York—Westchester Br.
240 North St.,
Harrison, N.Y.
Gowanda State Hospital,
Helmuth, N.Y.
Queens Hospital Center,
Department of Psychiatry,
82–68 164th St.,
Jamaica, N.Y.
Northeast Nassau Psychiatric Center,
P.O. Box 100,
Kings Park, N.Y.
North Shore University Hospital,
300 Community Dr.,
Manhasset, N.Y.
Marcy State Hospital,
Box 100,
Marcy, N.Y.
Middletown State Hospital,
Box 1453,
Middletown, N.Y.
Harlem Hospital Center,
506 Lenox Ave.,
New York, N.Y.
Bellevue Hospital Center,
First Ave. and 27th St.,
New York, N.Y.
Beth Israel Medical Center,
10 Nathan D. Perlman Pl.,
New York, N.Y.

The Roosevelt Hospital,
428 West 59th St.,
New York, N.Y.
St. Luke's Hospital Center,
421 West 113th St.,
New York, N.Y.
New York Hospital,
525 East 68th St.,
New York, N.Y.
Mount Sinai Medical Center,
100th St. and Fifth Ave.,
New York, N.Y.
St. Vincent's Hospital and Medical Center of New York,
153 West 11th St.,
New York, N.Y.
Jewish Board of Guardians,
120 West 57th St.,
New York, N.Y.
Kirby Manhattan Psychiatric Hospital,
600 East 125th St.,
New York, N.Y.
Meyer Manhattan Psychiatric Hospital,
600 East 125th St.,
New York, N.Y.
Rockland State Hospital,
Orangeburg, N.Y.
Creedmoor State Hospital,
80–45 Winchester Blvd.,
Queens Village, N.Y.
Syrono Memorial Hospital,
260 Crittenden Blvd.,
Rochester, N.Y.
Saratoga County Mental Health Center,
211 Church St.,
Saratoga Springs, N.Y.
Richard H. Hutchings Psychiatric Center,
620 Madison St.,
Syracuse, N.Y.
University Hospital of Upstate Medical Center,
750 East Adams St.,
Syracuse, N.Y.
St. Joseph's Hospital Health Center,
301 Prospect Ave.,
Syracuse, N.Y.
Hoch Psychiatric Hospital,
West Brentwood, N.Y.
New York Hospital, Cornell Medical Center, Westchester Division,
21 Bloomingdale Rd.,
White Plains, N.Y.
Willard State Hospital,
Willard, N.Y.
Harlem Valley State Hospital,
Station A,
Wingdale, N.Y.
Duke University Medical Center,
Durham, N.C.
Athens Mental Health Center,
Athens, Ohio
Cleveland Psychiatric Institute,
1708 Aiken Ave.,
Cleveland, Ohio
Fairhill Mental Health Center,
12200 Fairhill Rd.,
Cleveland, Ohio

Toledo Mental Health Center,
930 South Detroit Ave.,
Toledo, Ohio
Dettmer Hospital,
3130 North Dixie Hwy.,
Troy, Ohio
Harding Hospital,
445 East Granville Rd.,
Worthington, Ohio
Central State Griffin Memorial Hospital,
Box 151,
Norman, Okla.
Allentown Hospital,
17th and Chew Sts.,
Allentown, Pa.
Holy Spirit Hospital,
North 21st St.,
Camp Hill, Pa.
Easton Hospital,
21st and Lehigh Sts.,
Easton, Pa.
Hospital of the University of Pennsylvania,
3400 Spruce St.,
Philadelphia, Pa.
Western Psychiatric Institute and Clinic,
3811 O'Hara St.,
Pittsburgh, Pa.
Penn Foundation for Mental Health, Inc.,
Lawn Ave.,
Sellersville, Pa.
Somerset State Hospital,
P.O. Box 631,
Somerset, Pa.
Divine Providence Hospital,
1100 Grampian Blvd.,
Williamsport, Pa.
Butler Hospital,
333 Grotto Ave.,
Providence, R.I.
Vanderbilt University Hospital,
21st Ave., S.,
Nashville, Tenn.
Big Spring State Hospital,
P.O. Box 231, Highway 87 N.,
Big Spring, Tex.
John Peter Smith Hospital,
1500 South Main St.,
Fort Worth, Tex.
University of Utah Medical Center,
50 North Medical Dr.,
Salt Lake City, Utah
University of Virginia Hospital,
Jefferson Park Ave.,
Charlottesville, Va.
University Hospital,
1959 Northeast Pacific Ave.,
Seattle, Wash.
St. Joseph's Hospital,
19th St. and Murdoch Ave.,
Parkersburg, W. Va.
Dodge County Mental Health Center,
P.O. Box 68,
Juneau, Wis.

University of Wisconsin Hospitals,
1300 University Ave.,
Madison, Wis.
Dunn County Health Care Center,
Route 2,
Menomonie, Wis.
St. Michael Hospital,
2400 West Villard Ave.,
Milwaukee, Wis.
St. Croix Health Center,
Box 99,
New Richmond, Wis.
Wausau Hospitals, Inc.,
Maple Hill,
Wausau, Wis.

Lower Priority Projects

Mr. Shriver. You say that some lower priority ongoing projects may receive less funds under this budget that you are requesting than originally planned. Some may be terminated altogether.

Did you identify some that might be terminated in prior questioning?

Dr. Cooper. No, we did not. I did not in the questioning and I have not in fact. I would like to comment on that if I may, Mr. Shriver.

When I say "lower priority" I don't want to convey the notion here that these are poor projects. At the levels of our operation currently all these projects are quite good projects. I am talking relatively here. Other things being different I would not want to terminate them or reduce them at all.

Mr. Shriver. You wouldn't ask for any money if they were not good.

Dr. Cooper. That is right.

Mr. Michel. If you will yield, I think it is a very good point to make. Practically everything I hear is that it is a good laudible program, given the resources at hand at this time. But we are really under the gun this year, and it is all going to be that catastrophic if something gets delayed a year or 18 months before we can hopefully have the kind of resources again that we can go gung-ho and full speed ahead.

Dr. Cooper. The other thing is, in line with the previous conversation about the inappropriateness of those titles, the notion is often widespread that any scientist or any group that writes in for anyone of the categorical grants has a very easy time in getting the funds. Much to the contrary.

The rejection rate is extremely high in all the programs, so that this is a highly selected group to begin with and the competition is keen, so when we say we will reduce some, we will take into consideration those that are most near completion, those that can wait delay, and that is why we said we will do as much as possible on a case-by-case basis.

Evidence of Non-Federal Resource Availability

Mr. Shriver. You expect the State and local governments and other sources to pick up the slack resulting from Federal cutbacks of $157 million for some of these health programs.

Do you have any real evidence that that will happen?

Dr. Cooper. No, sir; I have no real evidence that this will happen. I am aware by hearsay that perhaps one or two States may be increasing the relative or actual percentage of their State allocations in public health matters to a modest degree, but I have no evidence at the moment that they will, without any further adjustment, be able to make these adjustments or would do it if the Federal share were reduced.

Professional Standards Review Organizations

Mr. Shriver. I am sure that you are aware of the unpopularity in some parts of the country, in some circles, of the PSRO's.

Dr. Cooper. Yes, sir.

Mr. Shriver. The actual operation of this concept is especially difficult in smalltown hospitals. I have been receiving quite a bit of mail on this subject. In my own State there are not enough doctors in the rural areas to make up PSRO's. I know the regulations have been delayed again and again in response to criticism.

I wonder if you would address yourself to this problem.

Dr. Cooper. Yes, sir.

I would like to distinguish two parts of the quality assurance activity here because sometimes they are interchanged as if they are exactly the same thing and they are not.

The regulations which were delayed that you are speaking about, about which there have been considerable calls and letters both to the Congress and to the Department, have to do with the regulations that were due for implementation on February 1 for what is called utilization review. It was particularly in rural areas where there are few doctors, where hospitals are small, and strict compliance with the regulations as they were written would be most difficult and difficult to execute on time, which resulted in the appeals to the Secretary to provide additional time to make some alternative arrangement to accomplish the objectives of that program. These objectives are to see to it that the Federal funds are expended appropriately for quality medicine. The idea here being that there are other ways, rather than just utilizing valuable physician time in this setting, in this time period, to get the job done.

The idea there is to allow the area to present to the State a plan which will achieve the objectives of the intent of the Congress about utilization review and quality medicine. The time was extended to July 1, as you know, to allow those in rural settings to provide alternative methods to accomplish this type of review.

As another feature of the quality assurance activities of the Department, PSRO's were initiated 2 or 3 years ago. We expect that there will be a nationwide network of about 203 units of physician-sponsored and manned review systems that will overtake and replace this concern about utilization review.

Where it is appropriate the PSRO's will integrate utilization review within its system. Where utilization review is inadequate, a professional standards review organization or foundation can provide the alternative service to give the doctor relief but still retain within his professional jurisdiction the responsibility for the oversight of professional activities.

This particular system, the PSRO system, which has been controversial, but which is gaining acceptance throughout the medical profession now, is not entirely in place. There are 91 planning units. There are about 14 units that are now conditional, and we expect this network to proceed.

In the interim, in order to obtain the objectives in the 1972 law on quality assurance requirements for utilization review, the other regulations were put in place. We think the extension of time and the interpretation that there are alternative possibilities that can be proposed to the States for the Secretary's review, plus the continued effort in the PSRO program itself to provide a network that can supplant and help with these types of activities will result within a year or 2 in a system that will achieve the objective of quality medicine and cost containment.

Mr. SHRIVER. Thank you, Doctor.

Mr. FLOOD. Mr. Smith?

PHS OFFICIALS IN "ACTING" CAPACITY

Mr. SMITH. Dr. Cooper, I want to wish you well in your new position. You follow a man who took the job very seriously and was willing to strike out on new courses.

Although the health establishment moves very slowly in terms of progress and change, constant attention to it will eventually, I am sure, warrant some success. I am trying to remember has your name been sent up?

Dr. COOPER. No, sir.

Mr. SMITH. I couldn't recall.

Mr. FLOOD. If the gentleman would yield, speaking of acting, I emphasized that when I introduced Dr. Cooper there is acting this and there are acting deputies and acting assistant deputies to the assistants. There are enough actors down there for an actors guild. It is about time they get rid of some of those actors.

Dr. COOPER. We hope to put that in order very shortly.

Mr. SMITH. It is a very important position and I just think some of these positions should be filled as quickly as possible on a permanent basis.

STATE CONTRIBUTIONS

With regard to health sharing which you devoted a good share of your statement to, and the other questions have been devoted to that, too, all of the States are given credit for contributions in kind and so forth until it is really rather difficult to tell by looking at statistics that I have seen what kind of contributions the various States are really making.

Do you have any tables that would——

Dr. COOPER. We could provide you with a breakdown of what this contribution is by program. The reason I just can't glibly give you an average figure is that the statutory requirement in different programs varies and, therefore, some of them are 90–10 matches for certain parts of staffing and the like, and we would be pleased to provide a table for you showing what the current contribution is in the variety of service programs for which we have suggestions for that.

Mr. SMITH. In addition to that I think in some States under some programs the contribution in kind is a service that was partially paid for by the Federal Government to start with.

Dr. COOPER. Yes. We have States assignees in some programs; yes, sir.

Mr. SMITH. So I really would like to get, if you could secure it for me, a listing of the net contribution by each of the 50 States to show some relative effort index of some kind.

Dr. COOPER. Yes, sir.

[The information follows:]

LEGAL MATCHING REQUIREMENTS

OF SELECTED PUBLIC HEALTH SERVICE GRANT PROGRAMS

PROGRAM	STATE OR LOCAL CONTRIBUTIONS
Alcohol Demonstration Programs	Unspecified - Grantee must assume some part of project costs.
Drug Abuse Community Service Programs	An increasing non-Federal contribution is required over the grant award period of three years. Poverty Areas: 10% - 20% Non-Poverty Areas: 20% - 30%
Mental Health - Children's Services	An increasing non-Federal contribution is required over the grant award period of eight years. Poverty Areas: 10% - 30% Non-Poverty Areas: 20% - 70%
Mental Health - Community Mental Health Centers	Same as for Mental Health - Children's Services
Childhood Lead Based Paint Poisoning Control	A 10% non-Federal contribution is required.
Communicable Disease Control	Unspecified - Grantee must assume some portion of project costs.
Urban Rat Control	Unspecified - Grantee must assume some portion of project costs.
Crippled Children's Services	A 100% match is required on fund apportioned under the "A" fund formula which consists of a $70,000 uniform grant plus an additional amount based on the number of children under 21 in the State.
Family Health Centers	Unspecified - Grantee must assume some part of project costs.
Family Planning Services	Under Title V a 25% non-Federal contribution is required. Under Title X, the cost sharing required is unspecified although grantee must contribute some non-Federal support.
Maternal and Child Health Services	A 100% match on formula grants is required.
Migrant Health	Unspecified - Grantee must assume some part of project costs.
Emergency Medical Services	A 25% to 50% non-Federal contribution is required.

Preventive Health Services

FY 1974 Distribution of Venereal Disease Funds

Location	Total Federal Obligations	State and Local Contribution
Alabama	$762,000	$48,333
Alaska	57,495	131,650
American Samoa	--	--
Arizona	177,001	78,657
Arkansas	267,667	58,478
California	2,689,995	897,338
Colorado	181,700	52,348
Connecticut	326,693	89,160
Delaware	61,316	19,335
Dist. of Columbia	447,619	178,694
Florida	1,643,831	43,200
Georgia	742,392	148,418
Guam	--	18,189
Hawaii	102,879	19,186
Idaho	31,042	128,570
Illinois	1,167,800	548,004
Indiana	289,286	23,458
Iowa	144,014	15,224
Kansas	132,108	56,515
Kentucky	356,000	15,241
Louisiana	286,068	129,990
Maine	63,000	29,180
Maryland	581,780	110,885
Massachusetts	112,955	803,545
Michigan	676,160	26,140
Minnesota	144,000	19,842
Mississippi	250,440	30,434
Missouri	629,853	105,982
Montana	84,000	13,759
Nebraska	116,025	8,187
Nevada	53,125	28,751
New Hampshire	54,380	2,456
New Jersey	671,430	134,636
New Mexico	173,910	14,463
New York	2,883,570	1,958,384
North Carolina	580,000	26,305
North Dakota	77,000	10,897
Ohio	1,684,187	227,720
Oklahoma	262,465	41,080
Oregon	178,453	183,356
Pennsylvania	669,114	128,187
Puerto Rico	275,000	58,352
Rhode Island	156,000	16,794
South Carolina	371,537	71,831
South Dakota	74,000	16,583
Tennessee	415,800	121,957
Texas	2,055,890	92,575
Trust Territory	43,000	3,661
Utah	83,808	11,153
Vermont	44,972	81,672
Virgin Islands	25,000	15,527
Virginia	433,656	58,267
Washington	363,010	260,519
West Virginia	87,515	6,311
Wisconsin	266,567	118,725
Wyoming	42,000	2,212
Evaluation	248,000	--
TOTAL	24,798,508	7,540,316

Preventive Health Services

FY 1974 Distribution of Immunization Funds

Location	Total Federal Obligations	State and Local Contribution
Alabama	$125,000	$8,569
Alaska	47,914	191,680
American Samoa	--	--
Arizona	156,035	60,852
Arkansas	105,481	362,920
California	335,838	158,750
Colorado	139,199	37,015
Connecticut	73,874	113,363
Delaware	36,718	58,997
Dist. of Columbia	71,020	27,251
Florida	211,200	91,490
Georgia	165,000	187,790
Guam	22,289	6,716
Hawaii	82,513	11,775
Idaho	30,266	13,657
Illinois	232,070	386,572
Indiana	64,052	12,377
Iowa	43,481	17,568
Kansas	129,346	7,110
Kentucky	113,640	2,000
Louisiana	189,771	153,294
Maine	40,077	157,400
Maryland	107,572	610,286
Massachusetts	241,369	1,050,000
Michigan	246,600	653,333
Minnesota	114,815	25,000
Mississippi	180,000	73,251
Missouri	140,107	26,962
Montana	40,869	16,699
Nebraska	35,701	500
Nevada	72,765	69,390
New Hampshire	15,225	6,143
New Jersey	304,139	61,897
New Mexico	78,679	23,723
New York	285,983	551,160
North Carolina	75,000	108,960
North Dakota	24,224	3,412
Ohio	239,208	5,200
Oklahoma	67,441	24,778
Oregon	208,321	93,473
Pennsylvania	100,671	285,855
Puerto Rico	101,633	28,221
Rhode Island	55,036	24,663
South Carolina	108,439	309,800
South Dakota	60,153	3,600
Tennessee	46,561	41,436
Texas	375,721	341,376
Trust Territory	31,636	14,620
Utah	40,991	22,695
Vermont	52,552	56,942
Virgin Islands	--	56,880
Virginia	82,534	234,673
Washington	5,361	30,500
West Virginia	88,485	11,658
Wisconsin	74,200	54,747
Wyoming	21,225	3,064
Evaluation	62,000	--
TOTAL	6,200,000	6,992,043

Preventive Health Services

FY 1974 Distribution of Rodent Control Funds

Location	Total Federal Obligations	State and Local Contribution
Alabama	$171,000	$26,414
Alaska	--	--
American Samoa	--	--
Arizona	--	--
Arkansas	100,686	62,416
California	595,516	152,873
Colorado	--	--
Connecticut	--	--
Delaware	--	--
Dist. of Columbia	718,884	444,327
Florida	--	--
Georgia	165,000	33,587
Guam	--	--
Hawaii	--	--
Idaho	--	--
Illinois	940,000	1,042,242
Indiana	249,000	113,858
Iowa	--	--
Kansas	119,658	3,418
Kentucky	205,000	133,626
Louisiana	271,479	171,332
Maine	--	--
Maryland	448,130	713,350
Massachusetts	79,336	23,397
Michigan	335,000	88,107
Minnesota	105,000	10,022
Mississippi	--	--
Missouri	452,762	526,413
Montana	--	--
Nebraska	--	--
Nevada	--	--
New Hampshire	--	--
New Jersey	1,030,725	3,295,104
New Mexico	129,498	5,299
New York	2,252,068	4,618,341
North Carolina	30,417	127,173
North Dakota	--	--
Ohio	358,749	161,899
Oklahoma	85,000	22,893
Oregon	--	--
Pennsylvania	2,509,503	2,604,621
Puerto Rico	265,109	126,040
Rhode Island	--	--
South Carolina	--	--
South Dakota	--	--
Tennessee	537,897	88,914
Texas	207,835	204,862
Trust Territory	--	--
Utah	--	--
Vermont	--	--
Virgin Islands	--	--
Virginia	62,840	85,636
Washington	191,908	42,855
West Virginia	--	--
Wisconsin	350,000	201,704
Wyoming	1,000	--
Evaluation	131,000	--
TOTAL	13,100,000	15,130,723

Preventive Health Services

FY 1974 Distribution of Lead-Based Paint Poisoning Funds

Location	Total Federal Obligations	State and Local Contribution
Alabama	$85,000	$49,093
Alaska	--	--
American Samoa	--	--
Arizona	--	--
Arkansas	--	20,000
California	252,225	87,490
Colorado	--	--
Connecticut	220,818	225,179
Delaware	70,111	14,527
Dist. of Columbia	398,534	231,997
Florida	--	3,336
Georgia	102,460	32,754
Guam	--	--
Hawaii	--	--
Idaho	--	46,590
Illinois	867,100	281,465
Indiana	20,625	12,716
Iowa	163,337	42,041
Kansas	121,990	13,651
Kentucky	281,700	42,340
Louisiana	180,796	116,038
Maine	255,950	74,257
Maryland	260,000	147,137
Massachusetts	796,107	263,037
Michigan	447,350	212,995
Minnesota	--	23,140
Mississippi	--	--
Missouri	174,098	280,960
Montana	--	--
Nebraska	--	40,423
Nevada	--	--
New Hampshire	--	7,859
New Jersey	400,000	404,408
New Mexico	100,000	24,138
New York	1,035,625	2,917,851
North Carolina	--	--
North Dakota	--	--
Ohio	609,000	287,903
Oklahoma	80,000	16,172
Oregon	--	--
Pennsylvania	1,131,492	193,288
Puerto Rico	--	--
Rhode Island	--	--
South Carolina	191,865	57,638
South Dakota	--	--
Tennessee	104,000	216,420
Texas	144,329	37,746
Trust Territory	--	--
Utah	--	--
Vermont	--	--
Virgin Islands	--	--
Virginia	165,488	85,175
Washington	--	--
West Virginia	--	--
Wisconsin	275,000	280,845
Wyoming	--	14,000
Evaluation	65,000	--
TOTAL	9,000,000	6,804,609

BUREAU OF COMMUNITY HEALTH SERVICES
SUMMARY OF TOTAL PROGRAM OBLIGATIONS
AND OTHER CONTRIBUTIONS
FISCAL YEAR 1974
(In Thousands)

STATE	Total BCHS Federal Obligations	State & Local Contributions	Other Federal 1/	Other Non-Federal	Total Non-BCHS Contributions
UNITED STATES	$715,783	$294,860	$ 66,270	$ 72,467	$433,597
Alabama	13,527	3,894	344	597	4,835
Alaska	1,386	1,553	192	605	2,350
Am. Samoa	578	285	---	---	285
Arizona	8,112	6,880	232	1,399	8,511
Arkansas	8,215	2,601	77	58	2,736
California	63,753	26,097	9,707	4,721	40,525
Colorado	17,555	6,064	1,276	5,163	12,503
Connecticut	6,191	3,723	200	491	4,414
Delaware	1,485	906	---	116	1,022
Dist. Columbia	14,664	4,664	2,795	2,276	9,735
Florida	24,698	21,723	476	4,144	26,343
Georgia	16,796	10,568	719	925	12,212
Guam	838	559	---	---	559
Hawaii	3,301	3,270	135	622	4,027
Idaho	2,760	1,171	177	135	1,483
Illinois	29,042	8,466	854	2,557	11,877
Indiana	8,300	7,004	165	6	7,175
Iowa	7,082	3,741	142	866	4,749
Kansas	5,313	2,118	108	347	2,573
Kentucky	13,762	5,936	258	216	6,410
Louisiana	10,797	2,361	184	194	2,739
Maine	4,880	1,363	282	865	2,510
Maryland	19,456	14,938	3,271	2,995	21,204
Massachusetts	18,982	12,902	4,976	3,738	21,616
Michigan	22,517	9,821	95	2,206	12,122
Minnesota	11,828	3,854	724	2,721	7,299
Mississippi	13,458	2,488	846	350	3,684
Missouri	19,103	5,898	1,101	6,909	13,908
Montana	2,875	1,249	8	305	1,562
Nebraska	4,208	1,743	96	682	2,521
Nevada	1,809	1,440	38	---	1,478
New Hampshire	1,928	904	64	121	1,089
New Jersey	13,386	6,113	537	1,860	8,510
New Mexico	6,150	2,100	547	127	2,774
New York	71,714	25,076	21,025	10,970	57,071
North Carolina	18,051	6,786	230	1,113	8,129
North Dakota	1,506	764	---	88	852
Ohio	31,758	14,378	867	1,488	16,733
Oklahoma	8,638	4,511	39	316	4,866
Oregon	9,105	3,578	473	257	4,308
Pennsylvania	32,960	9,936	6,955	2,033	18,924
Puerto Rico	14,830	4,914	145	1,274	6,333
Rhode Island	4,765	1,788	592	366	2,746
South Carolina	16,131	1,841	175	330	2,346
South Dakota	2,014	891	3	160	1,054
Tennessee	17,440	3,208	467	462	4,137
Texas	36,482	9,186	1,730	2,946	13,862
Trust Terr.	829	828	---	---	828
Utah	6,030	2,034	1,110	345	3,489
Vermont	1,486	705	14	182	901
Virgin Islands	1,760	856	---	75	931
Virginia	11,034	4,027	141	328	4,496
Washington	11,603	2,861	1,315	1,032	5,208
West Virginia	8,722	3,590	332	180	4,102
Wisconsin	8,381	3,866	16	186	4,068
Wyoming	1,279	839	15	19	873
Headquarters	530				

1/ Includes Titles IV-A, XVIII, XIX, and Other Federal Grant Support

IMPROVING HEALTH PRACTICE STANDARDS

Mr. SMITH. And I think myself that the greatest contribution that the States could make at this time to improving the medical distribution system, health delivery system would be if they would review their health practice standards and health practice rules.

We have been talking about that here with the HEW Secretary and the Secretary for health for a good many years because we don't have national licensure. We have State licensure. And if but the State Health Boards, would permit other health professionals to do what they are capable of doing under some kind of guidance from medical doctors, we could have a much better delivery system than we have, but it seems that none of the States wants to liberalize their health practice rules, and this would be the greatest contribution the States could make, but I am satisfied they are not going to make the changes unless there is a considerable nudge from your standpoint.

Would you comment on that?

Dr. COOPER. Yes.

The chairman mentioned earlier some of the ideas in our forward plan for health. Among those ideas is the expanded use of other health professionals to help the physician but under his supervision.

Clearly one of the requirements to accomplish this would be a revision of the State laws and in all cases to permit licensure of paramedical personnel for specified activities. This could be defined and be restricted to appropriate health practices.

The second area that we think is also important, is that the health examining boards and the local professional societies that are responsible for either certification or for reviewing medical practices should be aggressive in removing their colleagues who are not performing adequately. I think the profession itself sees this need as well as the appropriate utilization of physician extenders.

Mr. SMITH. Would you refine that. I am talking about legalizing what many doctors do, anyway, and that is permitting a nurse to do what she is capable of doing even when she is in the next room instead of immediately at his eye center.

MALPRACTICE INSURANCE

Dr. COOPER. I think I also would interpret it in the way that you have indicated in making clear what the legal authority is for the other health professional to perform certain activities. This interfaces quite seriously right now on several other areas, the most serious of which we mentioned earlier, the question of medical liability, and there is a great problem right now concerning malpractice, so-called, insurance.

Mr. SMITH. But this would even help with that problem because as it is now in a lawsuit they use as evidence of malpractice that it was illegal to have permitted the nurse to do in the next room what she was capable of doing. If it were legal, they wouldn't have that as a basis.

Dr. COOPER. This is a distinct feature in several cases. You are correct, sir.

Mr. SMITH. That is all I have, Mr. Chairman.

Mr. FLOOD. Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

Doctor, I have a number of questions I really don't have time for. I have a meeting in about 20 minutes. But let me ask you a question on HMO's.

On pages 7 and 8 of your statement you say you are asking for $18.6 million compared to $8.3 million for 1975. A year ago you asked for around $60 million, was it, and we cut it to around $18 million? Is that correct?

Dr. COOPER. There was a supplemental request for 18-month authority of $60 million, yes, sir.

Mr. OBEY. What is the holdup here? It would seem that that program is getting off the ground at a much slower rate than we had all hoped. What is the problem?

Dr. COOPER. It is going more slowly than we had hoped, Mr. Obey. There are probably several reasons for that. One is that it has taken a long time to get all the regulations out. The most important group of the regulations that is holding this up is the so-called dual option regulations. The difficulty here has been a discussion with the Department of Labor and other groups about the appropriateness of the dual option regulation.

The second feature is the benefit package itself, which particularly at this point in our economic history, prices out as a quite expensive package when compared to some other health plans and therefore the HMO has not been competitive in the sense that we had hoped it would be.

Thirdly, I think because of the overall economic climate there has been less enthusiasm for groups which were previously enrolled in this type of activity to enter into it because it has been shown on occasion, as you have read in the paper, not to be necessarily an automatically successful venture.

So at the moment, for reasons such as these, some of which are remedial, and some of which will have to wait on a better economic climate, the response to enroll in HMO's has been slower.

We think with the changes that could be introduced in this system, this could improve and we are looking forward to a better performance in the next year.

Mr. OBEY. What do you think that you can reasonably expect a year from now?

Dr. COOPER. About 150 to 170 active projects for grants and loans, if we were able to improve our performance on the basis of what I was just saying. Our planning estimates, as Dr. van Hoek indicated, would be to generate 130 operational HMO's by the end of the program.

Mr. OBEY. 138?

Dr. COOPER. 130.

Mr. OBEY. What was the number that you had originally planned to have on board by then—2 years ago, year and a half ago?

Dr. VAN HOEK. Our original plan in early 1974 was to fund enough grants so we would have 172 HMO's by the completion of the legislation, which was a 5-year program.

Benefits Under HMO Legislation

Mr. Obey. You mentioned problems with benefits. Do you think that the benefits listed in the legislation are realistic?

Dr. Cooper. They are very good benefits and the kind of benefit package which should eventually be in a good program of comprehensive health insurance. At this time, however, to get the program off the ground, we think the Secretary should have the capability of waiving some of the requirements in selected situations that would allow the program to be initiated.

Mr. Obey. Which are the most important? You say that he ought to have the authority to waive certain portions. Which ones?

Dr. Cooper. I would think that would depend on what the actual program proposed is. I wouldn't want to prejudge what the exclusion might be in any particular case. In some discussions that I have had with potential groups of people interested in developing an HMO, the nature of the dental package is one which created a special problem for them. In others it was not. In some cases, it was with the mental health coverage, and in others it was the number of mental health or dental visits, or the inclusion of various age groups in the dental coverage.

As I think rather than try to write specific regulations for what could be waived in given localities, what we are seeking is flexibility to permit the HMO to be competitive with other plans.

Mr. Obey. If you were to name 1, 2, 3, which ones would be benefits which seemed to be causing the most problems? You have dental and mental health. Do you have any others?

Dr. van Hoek. Mental health and dental health programs. Some of the aspects of alcoholism and drug abuse provisions also, although less important, because the law provides there that it is primarily acute medical treatment and subsequent referral to another agency for a followup. I think a critical issue is in the structure of the benefit package, what is available in the local community. If the State medicaid program has a very broad benefit package, then the marketability of that broad benefit package is easier. It is a very limited benefit package on the medicaid, that immediately restricts the coverage that can be provided for that population base and the income that can accrue to the HMO.

Forward Plan for Health

Mr. Obey. I will have some other questions on this tomorrow.

Doctor, the chairman mentioned the Forward Plan for Health. You made some comments on that, and you indicated that represented a plan—I forget your words, but you suggested that that plan was offered in the context of what could be provided if we had adequate resources. What appropriate amount could be expended? What dollar figures were you talking about in comparison with what you are suggesting in this budget?

Dr. Cooper. It was about $5.3 billion as compared to the current $4 billion.

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Mr. OBEY. A difference of $1.3 billion.

Dr. Edwards made a very interesting speech a short while ago, and he had a good deal to say about the problems he thought the country was going to be running into in being adequately prepared for national health insurance. That concerns me, and it is one of the reasons why I have not in the last 4 years signed on for the Kennedy health insurance bill. I think it is an ideal proposal, but I do not know whether we can handle it. I am not anxious to see a repetition of what happened with medicaid particularly. The amount in this budget for what you refer to as preparation for national health insurance—how does that compare with the amount suggested in the plan?

Dr. COOPER. It's less.

Mr. OBEY. By how much?

Dr. COOPER. Right off the top of my head I couldn't give you all those categories broken down. It cuts across the agency budget, there and some of the service budgets. My guess would be in the order of $300 million or $400 million.

Mr. OBEY. Mr. Michel referred to the economic problems that we have, but I think it is going to be very difficult to imagine this Congress not passing a national health insurance program in the next couple of years, or not trying to, anyway.

It would seem to me that any kind of plan which is passed without adequate preparation is an open invitation to disaster. I would think what amounts for preparation we would be spending now we could save many times over 7 or 8 years down the pike.

Dr. COOPER. Could I comment on that?

Mr. OBEY. Yes.

Dr. COOPER. We would agree that it is critical that the system develop the capability of responding to some form of expanded demand that will inevitably follow a program of universal or comprehensive insurance. I think we would recognize that the actual implementation of any of the plans that have been thus far discussed in the Congress, even after passage, would take 2 to 3 years before they become operational.

I would also say that among some of the more important developments that could help prevent what you interpreted there as problems with medicare and medicaid in 1965 are the reasons why we have given priority even at this time, when we are cutting back many programs to some of those systems development programs, like the quality assurance activity and the cost containment activities. We think some of the other areas, like manpower development and developing the aggregate capacity alone will not solve all of the issues that need be addressed. I think the budget requests that we are proposing for improving the health care system are not unrealistic in this sense. We are sensitive to the issues, and the need to prepare the health system for a form of national health insurance.

Mr. OBEY. I think your statement that any systems we plan will take 4 or 5 years to implement implies too much optimism, based on past experience, that whatever we do will give us enough time to be prepared for what happens. It seems to me we are running into an endless, round-Robin argument.

Dr. COOPER. No. I think that that is part of the attempt to try to be realistic about obviating the pitfalls. The other part is the nature of the bill itself. I think structured into any national health insurance bill must be also the specific provisions which will be essential for avoiding the previous pitfalls. I wouldn't want to demean or shortchange the complexity of what would be involved. Some involve developing the capacity in the health care system to provide care but others relate to specific provisions of the legislation itself.

OCCUPATIONAL HEALTH

Mr. OBEY. How much below the amounts suggested in the Forward Plan for Occupational Health is in the present budget?

Dr. COOPER. I don't recall that specific number. I didn't bring the Forward Plan for Health with me.

Dr. SENCER. I will have it for you tomorrow.

Dr. COOPER. Dr. Sencer could bring it in tomorrow, if that is okay, bring the Forward Plan in and have that number for you then.

Mr. OBEY. You don't know offhand what it is now?

Dr. COOPER. I can safely say——

Mr. OBEY. The plan suggested an increase of $9.7 million to "mount a comprehensive program of surveillance, industrywide studies and laboratory research for occupational cancer areas."

Dr. SENCER. We are $10 million from that.

Mr. OBEY. How could that be if you are asking for an increase, if the plan suggested an increaoe of 9.7 and you are $10 million from that? There was no response whatsoever in this budget?

Dr. SENCER. There is a response, Mr. Obey, in terms of direct operations, $1,250,000 in direct funds.

Mr. OBEY. In terms of overall dollar amounts, you are further away from the target than you were when the plan was written?

Dr. SENCER. This is because we are not requesting extension of authority for training grants in occupational health, which does reduce our comparative budget by $2 million from last year.

Mr. OBEY. In your testimony on the deferral and rescissions, I think you yourself granted that that was not especially logical, given the problems that you have in obtaining certain personnel in that field?

Dr. SENCER. That is right.

Dr. COOPER. That was not Dr. Sencer's recommendation.

Mr. OBEY. I understand that.

Let me save the rest of the questions on occupational matters for tomorrow.

Let me ask you this: I am very interested in the question and anxious to be as supportive as I can, but one of the things that bothers me is the degree of effective coordination between NCI, NIEHS, NOSH—you name it—in this whole field of environmentally induced diseases, cancer, occupational cancer, and the like. I would like for you to describe for me how that coordination takes place. After you have your meetings and the policymakers determine what that coordination ought to be, how does it settle down to the research level and operational level?

Dr. COOPER. The toxicology coordinating committee is made up of representatives from the specific agencies that you mentioned, plus some extra departmental representatives of relevant agencies. It is a

group whose charter program, staff support, and operational funding needs are reviewed annually by the Office of the Assistant Secretary in consultation with the Health Policy Board. The Policy Board consists of these gentlemen here at the table with me today. They are the men responsible for all the agencies that review these and all other coordinating committees.

In our planning process last year, when the individual agencies submitted program and budget to the Office of the Assistant Secretary, there were several of them who had specific requests for toxicological effects studies in the area of carcinogenesis. We took these proposals and each one of its substantive parts, and asked the group to review them to see if in fact there was duplication, whether the work was being done elsewhere outside the agencies or, to anybody's knowledge, whether the specific proposals were realistic, and then to give us comment on what its real priority need would be.

In that particular case we got advice from the committee about their relative activities in the area of carcinogenesis. Some of them turned out to be low-level chronic exposure studies. Some of them were developing methodology, and so on, and we were able to determine what the total part of that specifically increased effort would be. That committee operates also in other areas. Very often we are asked to respond on relatively short notice to some unexpected hazard that appears either in an industry or in a community. We will refer that, when it comes to my office, to the chairman of the toxicology coordinating committee, who can then call the committee together and get the best expertise in the agencies on what action to take. This often does not result in them having laboratory scentists in the specific agencies do anything in specific response incidence of hazards, but they respond to us about the expected health hazards, reliability of the data, and so on. In response to a specific mandate, if there is going to be new activity in a given area, we would ask this group to give us advice as to what appropriate activity would be most efficiently done, with what resources, and in which agency. After reviewing the committee recommendation we would see to it by the budget allocation mechanism that the appropriate activity would be assigned to a specific agency.

They are not a managing group. They are an advisory group to the Assistant Secretary for Health for that purpose.

Mr. OBEY. You mentioned that eventually you get to the budget allocation. Assuming the accuracy of the statement, which is heard over and over again and which is contained in the forward plan for health, the statement that 80 to 90 percent of all cancers are environmentally induced and by far the largest portion is attributed to the workplace, I don't see this reflected in the allocation of budget resources. I look at NIEHS and they are significantly down from last year.

Dr. COOPER. Yes, sir.

Mr. OBEY. NIOSH is given an increase of, 0.6 to 1 percent in your budget?

Dr. COOPER. Yes, sir.

Mr. OBEY. If that statement is true, why don't we see it reflected in the Government's budget? Even in NCI, the amount of resources devoted to occupational health problems is very meager.

Dr. COOPER. The point is very well taken. I would not try to wiggle that far off the hook in saying this does not require a careful look at

how the resources are being disposed of, even in the research for these purposes. I would make one point, however. I think the fact that one would contend that 60 percent or 80 percent is due to environmentally induced causes should not be necessarily translated into a requirement that the resources ought to be, 60 to 80 percent in that area.

The second point on that is since that statistic has been utilized widely, both in our own rhetoric and rhetoric of other nongovernmental groups, it has become clear what is meant by environmental, means a lot of different things to different people. Sometimes the distinction is made all the way down from the difference between genetic and nongenetic determination. I think your point is well taken. We should look very hard at it. If we are really talking about environment in the sense of chemical exposures in the environment, we should make sure that we are utilizing all of the opportunities that we have and so should the national cancer program in specific, as well as health programs in general, and to see that the National Institute of Environmental Health Services as well as NIOSH gets appropriate priority for funding.

Cancer Research

Mr. Obey. Dr. Edwards described what we now call the war on cancer as being "ill conceived." What is your attitude on that? Where do you come down on that?

Dr. Cooper. As I answered Mr. Natcher earlier, I don't know if you were here for that, I think you make that decision on the basis of three things.

Mr. Obey. Yes; you mentioned the three things, but what about the argument that politics got in the way of scientific judgment on this; where would you come down on it?

Dr. Cooper. As I intimated to him, if you ask me, given all the same money, would I have divided it differently, my answer would be, "Yes." I would have divided it differently. I think that is because I would see it from my perspective as a physician and scientist and quasi-politician. At that time, when it was done, I had a different constituency, and I made a big plea to have it divided differently. That is not to say that there are not a lot of other areas that could merit from the allocation of resources. If you are asking me that that money is ill conceived in that it is being worthlessly spent——

Mr. Obey. No; no one suggests that, obviously.

Dr. Cooper. Then my answer would be, "No." I think it is being well spent. If you ask my preference for distribution, I am sure if you ask anybody around this table, they would have a different preference and it would not be the same as mine.

Mr. Obey. I would like to know yours. You came from a different Institute I know, but I have enough confidence in your judgment, and other people have, too. One of the things that interested me is that——

Dr. Cooper. I guess the best answer specifically is because it is in black and white that you could follow, if you read in the forward plan for health, it gives our assessment of where we would distribute the money if we had that same amount of money.

Mr. Obey. That is all I wanted you to say.

Thank you.

ESTIMATES FOR DIABETES RESEARCH

Mr. FLOOD. Doctor, the Diabetes Research Education Act, signed July 23, 1974, became law. That requires HEW to transmit to Congress the estimates of the amounts requested for each one of the Institutes, insofar as diabetes research is concerned, within 5 days now after the 1976 budget is submitted. As of this date we don't have the information.

When do you plan to submit that estimate? We would like to have it before our markup.

Dr. COOPER. If I may, sir, I will refer that specific question to the Director of the National Institutes of Health.

Dr. LAMONT-HAVERS. The timing of the legislation and the implementation of the legislation in reference to the development of the budget was rather out of phase. We are considering the fact that the practical thing would be to consider the fiscal year 1976 to be a fiscal year 1977 budget. The presentation then ongoing from then on.

It would be very difficult for the Commission, which has just gotten underway, to gather sufficient information and make judgments with regard to the fiscal year——

Mr. FLOOD. That is very well, but we want it before the markup for the bill. The law specifically requires it be submitted within a certain period of time. We will soon be marking up a bill. That almost speaks for itself. Need I say more on that one?

Dr. COOPER. You would like specific recommendations by Institutes on what their activities will be?

Mr. FLOOD. Yes. We don't use mirrors.

Dr. LAMONT-HAVERS. What Mr. Flood asked for is their recommendations with regard to the fiscal year 1976 budget with regard to diabetes.

Mr. FLOOD. Yes. The diabetes matter will be covered later on in our public witnesses, too.

Dr. Cooper, in your capacity, for the record, this public law that I am talking about, 93–354, that started a new ball game, NIH was delegated to do the research for diabetes. The Director of NIH was mandated to do that. The chairman of the coordinating committee, that includes all Institutes and all Federal agencies, establishes a National Commission for Diabetes, which by law includes the following: I will read the alphabet soup in the record and you translate. NEI, HLI, NIMDS, NIGMS, NIMD, NIDR, NICHD. You and I know what those are, but straighten those out.

[The information follows:]

The member Institutes of the Coordinating Committee are:

National Eye Institute.
National Heart and Lung Institute.
National Institute of Neurological and Communicative Disorders and Stroke.
National Institute of General Medical Sciences.
National Institute of Arthritis, Metabolism and Digestive Diseases.
National Institute of Dental Research.
National Institute of Child Health and Human Development.

This matter was discussed at the organization meeting of the Commission on March 10, 1975. They determined at that time that more specific program considerations must be developed before they could establish valid estimated needs for expanded programs and new programs in diabetes research. The budgets to be presented by the Diabetes Commission will be developed as one portion of their

report based on testimony and data developed in the course of their deliberations. The Commission indicated it would be unwilling to develop budgetary figures before their program recommendations were firmly defined. They plan to make specific recommendations with respect to the 1977 budget. The Department is also reluctant to develop budgetary figures for a program that won't be firmly defined until December 1975 when the Commission report is anticipated. A similar problem exists with respect to the National Arthritis Act of 1974.

Diabetes as a National Health Problem

Mr. Flood. There you have two functions, to recommend budgets for each one of those involved institutes and also recomend a long-term plan for cooperative research spelled out. Suppose you tell us now what you are going to do about that diabetes. There it is. How could you assess diabetes? It is a national health problem?

Dr. Cooper. I think diabetes is an extremely important national health problem. In some statistical reports it is now listed as the third cause of death in this country.

Mr. Flood. The third cause of death?

Dr. Cooper. Yes, sir. It afflicts 300,000 people as diagnosed diabetics. Besides being recognized as a metabolic abnormality in the body, it has secondary effects on a wide variety of organ systems throughout the body. I am sure that that is why the Congress mandated that all these various Institutes participate in this deliberation, and the National Eye Institute, because the primary cause of blindness in this country results from diabetic retinopathy; The National Heart and Lung Institute, because diabetes is a frequent traveler with arteriosclerosis and is associated with the problem of a heart attack, a very important risk factor in the problem of arteriorsclerotic heart disease. It is a factor in neurological disease as it affects the circulation to the brain. It is a factor from a genetic standpoint because some of it is of not an acquired nature. It affects the kidneys, it affects the liver as well as the primary organs of insulin deficiency, from which it was originally studied. This was the reason why the call came from the community that if there were to be a commission to study this problem that it should encompass all the peripheral manifestations of this condition.

We have had tremendous success in alleviating the consequences of the metabolic abnormality. Twenty-five years ago, 30 years ago, many people died in diabetic coma because of the mismanagement or inability to manage their abnormal metabolism of sugar and fat. That has been corrected but it has not changed the progress of secondary organ impacts this condition has. What is being called for here now is an expanded effort to study its impact on the target organs that it affects. This is why the Commission, I presume, by the Congress, was called on to have the Director for all these programs as well as a group of scientists from outside speak to it.

In response to that act, the Commission held its first meeting March 10 or 11 and it will not be scheduled to complete its report until December 1975.

In that sense I would have to interpret Dr. Lamont-Havers' response that it is quite unlikely that we would have recommendations on specific Institute budgets in all those seven areas from the Commission.

By the time you mark up they will have just begun their deliberations and certainly we would recommend that you get their best advice, as I said in my opening statement, before that decision was made.

I think in the interim it behooves us to ask each of the Institute directors to make sure that with the resources that are made available that they take advantage of every scientific opportunity available to support reasearch that speaks to this important problem.

Mr. FLOOD. For the reasons you state there it is, right there now. Congress has put it there and so you have in the last 10 minutes.

Dr. COOPER. Yes, sir.

HEALTH EDUCATION

Mr. FLOOD. In this budget, for the Center Disease Control, there is a program you call health education. You can't beat that, health education. One of the goals of this program in 1976 is to initiate and to stimulate health education programs. They are designed to meet the specific need, and you have a target population, you have minority groups, you have urban, you have the rural poor, and you have the elderly.

If this program does the job properly as you say it should and will, then its effort are going to result in many, many individuals in those various groups who are going to go out seeking health care. Am I correct?

Dr. COOPER. In part.

Mr. FLOOD. All right.

If that is so, even in part, we have trouble understanding how on one hand you have a program which is going to create the awareness of the need for good medical care; then, on the other hand, you are cutting back on most of the very programs that these people are going to be turning to for that medical care—maternal and child health, neighborhood and health care centers, et cetera, et cetera, et cetera.

You are cutting them all back. How do you explain that? Is that a conflict in policy

Dr. COOPER. Let me give it a try and try to divide the problem this way.

We think there are many areas of health education which can begin very soon which are not necessarily in the nature of driving people to seek physicians or to seek health care. One of the great unused national resources for health care is the individual himself. This is a very difficult task to do, to try to get people to change their lifestyle, their eating habits, to give up smoking, and so on. There is a great need in health education to begin to attack this problem and I think that is a part of the problem which will drive the people to physicians and health care areas.

Mr. FLOOD. As you have heard me say, Dean Pound, of the Harvard Law School, would ask me a question and then I would think about 30 minutes talking and he wouldn't say a word. At the end of my 30-minute speech he would say, "Mr. Flood, you have just restated the question."

Dr. COOPER. I was trying to divide the answer into two parts.

One is we think there is part of the program that will not create demand but is absolutely essential to bring information to the American public.

The second part could create demand and will seek preventive services. The preparation of the system and the paradox in policy that you point to is rationalized on the following basis: Although we have advo-

cated the reduction in the Federal share for the operation of these facilities, we would hope that the State and local agencies would pick up the difference so that the capacity for care would not be reduced and therefore the health education objective could go forward.

Quality of Nursing Home Care

Mr. Flood. You spent some time yourself in your original statement on the nursing homes, but if I can understate the case, if ever anything has been getting a lot of attention lately it is this matter of nursing homes, all phases of the nursing homes.

As a matter of fact, HEW published its own report on the deficiencies that exist in all kinds of nursing home care. What in the world are you planning to do under this budget that you have here to improve the quality now of nursing home care?

Dr. Cooper. We intend to keep this activity at the same or greater level. In conjunction with the Office of the Secretary we will be expanding the staff that will be instrumental in implementing the new regulations for this particular program.

This is an area in which we are not recommending a cutback, Mr. Chairman, in resources. We think that this effort should go forward. It is one in which we have made substantial progress and is one on which we would propose to the Secretary in the future some expanded initiatives.

Mr. Flood. You certainly made very clear in your affirmative statement your awareness of the problem, but now when you examine this record out of an abundance of caution, if for no other reason, in reply to my question you can go on, not now, but for the record.

Dr. Cooper. We will specify what activities need to be done, what activities we are proposing in this area.

[The information follows:]

PLANNED ACTIVITIES IN LONG TERM CARE

The Department's long-term care strategy is designed to continue the implementing of the President's Eight-Point Nursing Home Improvement Program, new requirements of P.L. 92-603, and achievement of basic improvements in the long-term care delivery system. One method for improving the quality of care provided in long-term care facilities is the Long-Term Care Improvement Campaign. The initial Campaign project is the ongoing Long-Term Care Facility Improvement Campaign (LTCFIC) analysis. The data gathering for the project was completed during November 1974.

Task forces composed of health professionals are now developing procedures to prepare the data for computerization and analysis preparatory to issuing a series of reports that will present the findings of the study and recommend a national strategy for addressing specific problems identified. In-depth periodic reports are planned until the data are fully analyzed during 1975. The findings that will be revealed will provide not only a perspective of the quality of care being rendered, but also a basis for substantive planning in the areas of:

A. Development of a Cost-of-Care Index for Long-Term Care

A monthly cost-of-care index will be set up and maintained by DHEW to serve in the long-term care reimbursement areas as the BLS cost-of-living index serves in the wage-rate and other areas of the economy.

B. Development of a National Rating System on Quality of Care Provided

Patterned after the PHS Federal-State Milk Inspection Model, developed by the U.S. Department of Agriculture and used uniformly and successfully throughout the country for years to certify dairies and milk producers, a project will be undertaken to:

(1) Provide intensive training of State inspectors of LTC facilities at a special center. Following training, the inspectors would be nationally credentialled to make inspections in nursing homes in all States. State certification and licensure of all inspectors is our national goal.

(2) Develop a weighted score card to be used for grading nursing homes (both SNFs and ICFs) uniformly throughout the nation, so that an "A" rating would mean the same thing in one State as it does in another.

C. Training of Nursing Home Personnel and Other Health Professionals in LTC

The training of provider personnel to upgrade the performance of long-term care health personnel will continue to be given high priority. A wide-range of short-term and continuing education courses will be provided for all categories and levels of nursing home personnel and other health professionals in LTC.

D. Improvements in the Structure of Existing Health and Safety Standards for Skilled Nursing Facilities

Deliberate, well-planned efforts will need to be continued to enforce existing standards, implement the current Life Safety Code, develop new standards, provide technical assistance, and develop and utilize a data system, "Management Information System" (MIS).

Several of the data programs developed or being developed within the Department contain certain information about long-term care facilities and needs. These include the National Center for Health Statistics' Nursing Home Survey, the Bureau of Health Insurance of the Social Security Administration's Health Insurance Data, and the Medical Services Administration of the Social and Rehabilitation Services' Management Data. Attention will be given to consolidating these data and to help develop a more consistent data base at both Headquarters and Regional levels. Initial operation of the MIS started in March 1975.

E. Upgrading State Survey Agency Performance through Surveyor Training

Training efforts will continue to focus of improving the interpretation and uniform application of federal health care standards and the overall management of State certification programs. Basic, advanced, and supervisory training courses of State agency personnel will prepare new surveyors, supervisors and administrators in the certification process.

Emphasis will continue to be placed on the professionalization of the surveyor through the further application and development of this career ladder concept of training. University based programs will be employed as well as the granting of graduate credits and the certification of surveyors. The integrated system of training will encourage the retention of surveyors and provide a core of high calibre State surveyors.

F. Improvements in the Survey Certification Process

The effective performance of individual surveyors and the conduct and management of the certification process will be further supported and strengthened by training funds and technical assistance to the States for training survey personnel; by the annual inventory to identify all currently employed surveyors; and by the evaluation of individual surveyor performance.

G. Innovations in the Delivery of Long-Term Care Services

By drawing implications from the LTC Survey data, the PHS strategies will move toward the goal of encouraging innovative approaches to the delivery of Long-Term Care Services. Research, development, and evaluation as well as providing technical assistance will be among the methods to be utilized to improve the delivery of long-term care in both institutional and non-institutional settings.

In addition to the above, PHS will serve as the departmental focal point for Home Health Services (HHS). Program activities planned to carry out PHS responsibility include three major areas:

A. Development of Training and Technical Assistance Materials. Publications presenting concepts regarding prevention of disability and dependency through community in-home service supports will be updated. Using several models, a guide to the organization of HHS agencies will be developed, paying particular attention to problems of both multi-agency communities as well as less advantaged and rural areas. Another document will illustrate several "success stories," using actual experiences of agencies (such as the Home Health Service of Northeastern Pennsylvania) in developing their programs and describing commonalities and differences in organization and service delivery. The text to accompany the National inventory of homemaker and home health agencies (obtained under contract) describing how it can be used, will be prepared and the document published.

B. Data Collection and Analysis. Information on several different HHS data collection systems will be gathered and representatives brought together to develop a basic data set and a strategy for collection. Using the first-stage data collection instrument developed under the inventory contract PHS will carry out an in-depth study and revision of data collection instruments.

C. Short-Term Training. All DHEW regions will be encouraged to conduct meetings and workshops for official and voluntary provider and professional agencies, and consumer and public leaders to foster the development and appropriate utilization of HHS. With help from SSA, SRS and AOA in development of regulations, guidelines, and training materials for providers, PHS will encourage the Regional Offices to assess local needs and offer technical assistance and/or training in a range of areas such as program assessment or fiscal accountability. Community programs in casefinding, aimed at reaching those in need, would also be developed and supported.

SUMMARY: By building on previous efforts, in cooperation with Federal and National agencies, and with Regional Office assistance both in identifying resources and needs and in providing local learning opportunities and technical assistance to community groups, PHS will refine concepts and strategies, improve data collection instruments and systems, and disseminate the best information available that can assist in expanding appropriate use of in-home supportive health care systems to prevent or postpone dependency or institutionalization.

PHS OFFICIALS IN "ACTING" CAPACITY

Mr. FLOOD. Just this last thing.

We mentioned this briefly a few minutes ago. In addition to yourself, how many key positions in the Public Health Service—by that I mean the agencies, the directors, the institutes, the bureau directors—are in an acting capacity now?

Dr. COOPER. There are myself, three agencies of the six have acting heads, there are two institutes at the National Institutes of Health that are vacant, as is the directorship of NIH, one bureau at the HRA is acting, and one institute at CDC is acting.

Mr. FLOOD. That is eight. When do you intend to install these positions with some degree of permanency? What is the scuttlebutt?

Dr. COOPER. The scuttlebutt is that we hope to do it soon, sir.

Mr. FLOOD. That is great.

Thank you.

Mr. Michel?

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. MICHEL. Let me follow up here if I might, Mr. Chairman.

Dr. Cooper on PSRO's, how many States now are totally or partially involved in the PSRO program?

Dr. COOPER. We have 91 planning grants in 43 States.

Mr. Weinman, the deputy director of that program, is with us.

Mr. MICHEL. What is the problem with the remaining seven? There is nothing being done there?

Mr. WEINMAN. I think some of those have already indicated interest and there is a possibility that given any new planning grants this year that some of those States might be brought in, maybe as many as two or three more.

Mr. MICHEL. What do you figure is the total number of doctors involved thus far in this?

Mr. WEINMAN. About 85,000.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. MICHEL. Then on HMO's, did I read some place or see a television newscast or something with respect to decertification of some out in the State of California or a problem that resulted from maybe——

Dr. COOPER. HMO's?

Mr. MICHEL. It had to do with HMO's.

Dr. COOPER. There was a recent investigation of prepaid health plans in the State of California some of which were probably HMO's managed by the State but some of them were not HMO's. Not every prepaid health plan is in an HMO.

Mr. MICHEL. So when we talk about HMO's, as you know, some Zenith or something, it doesn't necessarily mean because you established an HMO you are home for free; right?

Dr. COOPER. No, sir. I think the intent of the legislation actually was to provide a time period in which various models could be assessed for their usefulness in various local settings. I think we have come to the idea that it is not a panacea but it is a mechanism that should be

available, at least tried, as a competitive means for providing comprehensive services.

Mr. MICHEL. Have we had a long enough shakeout period here to really make a good assessment?

Dr. COOPER. We do not think we have as yet, sir.

MALPRACTICE INSURANCE

Mr. MICHEL. I would have to agree.

On this malpractice insurance matter with which you dealt in one paragraph here, isn't it a generally accepted practice in a State, currently, for the medical association to choose or to determine one insurance carrier in the State to handle those which they would recommend their doctors participate in?

Dr. COOPER. Some societies have dealt with a single carrier but this always has to be approved by the State insurance commissioner if that is the proposal being undertaken.

Mr. MICHEL. I agree with you that the subject needs a great deal of discussion and aeration on all sides. I am concerned when I read about some of the outlandish premiums that are leveled. By the same token, if there is a level premium regardless of the standard of care or standard of professionalism of the doctor, that doesn't square very well with me.

That is what the "name of the game" is all about. For those who have a proven good track record, it seems to me there ought to be a mechanism for declining premiums if that is the case.

Dr. COOPER. There are risk categories, Mr. Michel. There are five risk categories that are currently available and the highest risks, class five, are specialists like the plastic surgeon, the orthopedic surgeon, and the neurosurgeon.

It is not that they are worse doctors by any stretch of the imagination. It is that they deal with types of problems, injury from which might result in more severe or debilitating conditions. There is a whole raft of types of questions that have to be addressed here, and I think one of the unfortunate aspects of the crisis, as it is called now, is that injury from medical care is often equated with incompetence of a physician or malicious negligence or something of that order, whereas an injury per se can result from very good treatment which might have been necessary to accomplish some other objective. Very often this is classified as an injury and if it is in a certain category can be sued for and one might under current tort law get a substantial judgment, and I think some of these kinds of distinctions between real negligence and injury, which is unfortunate but really is not malpractice in any sense of the word, need to be distinguished.

Also within that same group of things it might happen that you are on the examining table and you go to step off onto a stool and you slip off the stool and fall down and injure yourself. The doctor is sued for malpractice sometimes and that is negligence like you might have on your property or in your office but that is a different distinction, so I think we have levels of definition there that need to be discussed.

We do have, for some reason that is not entirely clear, an increasing number of claims, increasing size of awards, and I think that we do not have the data that we need from the insurance industry to assess what the real extent of injury is and what the nature of those injuries is and

whether or not people are really getting appropriate redress for their injuries.

I am concerned that for small ones, because there might not be enough money, proper attention might not be paid to that. There are two sides even to that aspect of the problem.

But we have taken the position in trying to resolve this, and the Secretary has aggressively worked with all parties, as I mentioned in my testimony, that what we really think is that this is a State regulatory problem and not a Federal regulatory problem.

There are obvious Federal activities that could be undertaken to facilitate the idea and we support those very much, the getting of the data, exposing and evaluating the problem, but it is the actual regulation of rates, setting of rates, alternative developments of insurability, which is the acute problem, which ought to be handled by States, with their State commissioners in concert with the various professions involved.

Mr. MICHEL. It is quite by accident that while I was home for the Easter recess and went to my doctor to have my eyes reexamined after 4 years, he made the point to me that he is on the board of the local hospital there that has recommended in times past oxygen for prematurely born babies. Then most recently the case evolved after a number of years of blindness that was attributed to apparently too much oxygen when that child was a preemie, and the doctor is asking me the question, "Bob, what does that hold for me in the future? What if, for example, some child for whom I recommended oxygen as a premature baby 20 years ago today comes into court and says, 'I am partially blind and you are held responsible, Doctor.'"

Of course he knows much more today than he knew 20 years ago, et cetera. There are so many, many things they are on which we ought to have a much more thorough and far-reaching discussion of before plunging into doing some things we are going to regret.

Dr. COOPER. I think that was quite an inappropriate judgment. It involved two concepts, one of which is the statute of limitations concept for how long are you vulnerable, but more important than that is what was the standard of practice at the time and what was the intention.

I think this is important down the road, when we get our quality assurance mechanisms in place that for the long-term solution, we look at the appropriate mechanisms for adjudicating appropriate compensation for injury.

NATIONAL HEALTH SERVICE SCHOLARSHIPS

Mr. MICHEL. In the area of student assistance support of $67.5 million for National Health Service scholarships, how many students do we actually have involved in that particular program today?

Dr. VAN HOEK. 2,300.

Mr. MICHEL. Also, in that repayment of educational loans for doctors practicing in medically underserved areas, how many would be involved there? If you don't know it just put that in for the record, will you please.

Dr. VAN HOEK. Yes, sir.

[The information follows:]

As of April 1, 1975, 268 applications for loan repayment have been submitted and 203 agreements sent to participants. The 203 applicants consist of 168 physicians, 32 dentists, 2 nurses, and 1 pharmacist.

COMMUNITY MENTAL HEALTH CENTERS

Mr. MICHEL. And in these community mental health centers where there is a declining participation over the 8-year period down to, I think, a level of—what? Thirty percent is the lowest?

Dr. COOPER. Thirty percent.

Mr. MICHEL. Have there been instances of any communities defaulting or being unable to come up with the difference that was prescribed under the enabling legislation, because, frankly, the grant is all set aside for the entire length of the program, is it not, for a given community?

Mr. MILLER. No. We are committed but the money isn't set aside. We are committed to pay it.

Mr. MICHEL. Are there any instances where we have had to cut them off because of failure to meet or comply?

Mr. ISBISTER. Not for the fiscal reasons that you are describing.

Mr. MICHEL. Not for those reasons, but there have been other reasons?

Mr. ISBISTER. Most of the community mental health centers have been meeting their obligations for the non-Federal match through the course of the 8-year Federal grant. The real test will be coming this year because there are a number of centers which are now in their eighth year of their grant and they are experiencing varying degrees of difficulty in terms of meeting the non-Federal match, but I think the real test and the answer to your question will come this fiscal year.

Mr. MICHAEL. That bothered me all along because the very mechanism for setting it up was one of moving in a transitional sort of way, and I thought over quite an extensive period of years that if they couldn't cut it by that time when they were in for long-term, perpetual support at the Federal——

Mr. ISBISTER. But most of them have been successful in terms of garnering the income as I indicated and sources of revenues necessary to keep in operation.

RELATIONSHIP BETWEEN NCHSR AND NCHS

Mr. MICHEL. It would seem that activities by NCHSR, NCHS and activities under the recently enacted Health Planning and Resources Development Act of 1974 are closely related. What kind of effort is being carried out to coordinate these activities so that we can benefit from the available information and more effectively use available resources.

Dr. COOPER. We are keenly aware of the need to coordinate existing activities in the National Center for Health Statistics and the National Center for Health Service Research in carrying out the provisions of the new planning legislation. The data needs of the new health system agencies are being carefully analyzed to determine how the existing and planned data collection activities and capacities in the National Center for Health Statistics can most effectively contribute to these needs. Similarly, we are coordinating research activities and plans in the National Center for Health Services Research with the planning program, particularly with respect to planning technology and regulatory methods. Finally, we are closely examining other components of HEW to determine how their resources can contribute to the implementation of Public Law 93–641. While these activities are intended

to maximize the usefulness and benefits of available information and activities, it is essential to recognize that the new planning legislation contains provisions which require new directions from the traditional activities in which these organizations have been involved. We will insure that in the process of establishing newer activities we utilize existing capability and capacity. To that end, we are exploring various interbureau mechanisms to provide for information exchange, to develop short- and long-range plans for cooperative efforts, and finally to develop joint efforts to assist the development of State and local planning programs.

Cut in Cancer Request

Mr. Michel. As the budget now stands, you are asking us to appropriate substantially less money for the war on cancer than is appropriated in 1975. On what grounds could Congress justify such an action?

Dr. Cooper. The budget is $605 million for cancer is one-third of the total NIH budget. This represents a considerable effort. Obviously, some research projects will not be continued at the 1975 level nor will any expansion of overall ongoing programs be permitted. Howver, the budget request will still permit the NCI to pursue new leads and support the highest priority projects.

NIH Research Results

Mr. Michel. You mention a number of significant research findings in your statement. Do you consider these the major advancements which have resulted from the NIH research programs?

Dr. Cooper. The advances cited were examples of significant research being performed under NIH support. There are, of course, many others that could be mentioned, including studies of the viruses responsible for serum hepatitis, and the development of radioimmunoassay techniques for measuring very minute amounts of hormones and other biologically important substances. I'm sure that when the individual institute directors testify they will be able to supply you with more examples.

Conquering of Major Illnesses

Mr. Michel. Have there been any major breakthroughs which have put us significantly closer to conquering any of the leading illnesses in this country? Or are you particularly close in any area?

Dr. Cooper. Our understanding of the cause of disease processes and of ways in which they may be controlled is based on continued research on a broad front. This understanding is accelerated by periodic major breakthroughs in technologic tools or in conceptual models. The radioimmunoassay technique mentioned above is such a technologic tool. Understanding of the enzymatic defects in various genetic diseases constitutes such a conceptual model. But the leading illnesses today still require much more research. Diseases such as cancer and diabetes do not have a simple, easily recognizable cause and cure. They are complex conditions in which viral, genetic, immunologic, and other factors are important. Thus, advances in these fundamental sciences will continue to contribute to solving these disease problems.

Ambulatory Care Facility

Mr. Michel. I understand that you are planning to build an ambulatory care facility at NIH. Could you describe what the purpose of this facility would be? When you are cutting back on construction everywhere else in the budget and none of the people who write us about applications are able to get them approved, why should we go along with an expensive new building at NIH?

Dr. Cooper. The primary purpose of the ambulatory care research facility (ACRF) is to accommodate the gradual shift in the method of performing clinical investigation from the inpatient to the outpatient mode as illustrated by the increase in ambulatory visits from 25,000 in 1967 to a projected 75,000 in 1975. The rate of change is anticipated to accelerate as evidenced by documented projected program needs for 200,000 ambulatory visits by 1980. Of equal import, the ACRF will provide the opportunity to rectify existing clinical center problems which include the obsolescence of certain patient facilities and the lack of space or improper location of essential diagnostic and therapeutic services. The ACRF is essential to the maintenance of the highest quality of clinical care to support research programs at the NIH.

National Health Service Corps

Mr. Michel. My understanding is that just under 100 communities where the National Health Corps has placed doctors will continue on their own without Federal funds. Does this mean we can use these funds to extend the program to additional communities?

Dr. Cooper. In the case of the 68 communities in 1975, where National Health Service Corps support is no longer required to provide care to the community, the positions and resources required to support these practices have been utilized to develop new practices and to assign personnel to additional communities. The department's program plan calls for the capability of establishing an increasing number of independent and self-sufficient sites each year and utilizing these resources to develop additional community practices where National Health Service Corps resources may be utilized. The present program plan anticipates that from 25 to 30 percent of staff sites will become independent and self-sufficient each year beginning in July of 1977.

Mr. Michel. What's the long-range outlook for this program? Do you look forward to a time when the program will be self-sustaining with only minimal Federal support?

Dr. Cooper. I would like to ask Dr. van Hoek to answer that.

Dr. van Hoek. The program presently is demonstrating its capability as a very cost-effective approach to the geographic maldistribution of professional manpower and cost projections over the next 3 or 4 years indicate that the average cost for each professional placed in the field should not exceed $35,000 to $37,000 per professional for total program costs—including program management, recruitment, and site development. It is important to point out that the cash receipts collected for the services of the National Health Service

Corps professionals at site are first utilized to support the basic health care practice and that presently about an additional 800 health support staff are employed at National Health Service Corps sites without Federal funds being required.

In addition, it is anticipated that during fiscal year 1975 over $2 million will be returned to the U.S. Treasury as the reasonable costs of National Health Service Corps personnel assignment being collected from the communities' cash receipts collected in the health practices. It is anticipated that the amount to refund to the Treasury in fiscal year 1976 will be in excess of $3½ million.

Since a major expense of he National Health Service Corps is the recruitment and site development activity conducted for up to 200 new communities a year and the assumption of initial start-up costs for National Health Service Corps practices in the 12 to 24 months, the program would not be expected to be fully self-sustaining as long as new communities were being developed and supported during the initial period. In addition, there will be a number of cases—projected at less than 10 percent—where due to unique factors of isolation and low population densities or very low socioeconomic levels in the communities, that the National Health Service Corps will need to continue indirect support, through assignment of personnel, until such time as a national health insurance plan assumes the costs of the primary care services being delivered. However, the program has been and will require a relatively minimal amount of direct Federal support.

Public Health Service Hospitals

Mr. Michel. What was the average daily patient load for the PHS hospital in 1973–75? Isn't the rate of usage of the facilities rather low?

Dr. Cooper. The average daily patient load for the PHS hospitals was 1,655 in 1973, 1,523 in 1974, and we are estimating 1,648 for 1975, which represents about a 69 percent occupancy rate. This compares to a nationwide occupancy rate of about 74 percent. The rate of usage is not really that low when you consider that there has been a national trend toward decreased utilization of inpatient care and increased utilization of ambulatory facilities. In the case of the PHS hospitals, there are additional factors which tend to lower the patient workload, particularly in 1974 and the projected load for 1975. That is, budget restrictions and the continuing threat to close the PHS hospitals have contributed to lower utilization in our facilities. The trend since the passage of Public Law 93–155 has been on the incline and given adequate resources, is projected even higher for fiscal year 1976.

Mr. Michel. Is it this low usage that is behind the Department's efforts to increase community participation in hospital programs, including the proposed transfer of two facilities to community control?

Dr. Cooper. The administration's policy in recent years, has been to reduce the Federal Government's involvement in the direct delivery of health care services, where other alternatives exist. With the passage of Public Law 93–155, mandating that the hospitals remain open, we have been utilizing the unused capacity in the PHS hospitals to provide

health care to selected community programs where other community resources are not available or adequate, and where we have the capability to render this assistance.

As for the transfer of facilities, the Health Services Administration is developing a study of the cost effectiveness of selected hospitals. Based on the results of this study, a decision will be reached, a proposal developed, and submitted to Health Planning Agencies for review and approval. After these steps have been completed, legislative proposals could be developed proposing transfer of one or two hospitals to community use. To date, there has been no decision as to how many or which might be transferred.

Emergency Medical Services

Mr. Michel. How many areas of the country have been provided assistance in establishing emergency medical services systems since the program was enacted in 1973?

Dr. Cooper. In fiscal year 1974, the first year of the grant program, we provided assistance in emergency medical services systems planning and operations to 45 of the 50 States, Puerto Rico, and the District of Columbia. In fiscal year 1975, it appears that we will receive applications from at least four of the five States that did not receive assistance in fiscal year 1974. This is exceptionally broad coverage for a new program.

Mr. Michel. What percentage of increase does this mean in population to whom such services are available, and how many people will eventually be served by projects already funded when they are fully operational?

Dr. van Hoek. As a result of assistance provided during fiscal year 1974, there are 28 emergency medical services systems in some phase of operational development. These systems serve a population of about 11,500,000 persons. In fiscal year 1975 we expect to fund 29 additional systems. This will increase the population served to approximately 28,500,000 persons, an increase of almost 150 percent over fiscal year 1974.

Mr. Michel. Isn't the Department requesting a legislative extension of this program to allow time for additional projects to be funded?

Dr. van Hoek. Yes; the Department is requesting a legislative extension of this program to allow time for additional projects to be funded.

Mr. Michel. What kinds of programs have been developed at the State level along these lines?

Dr. Cooper. Basically two types of programs are being developed at the State level. The first involves designation, development, and maintenance of a State agency—in most instances the State department of health—to administer the program and to provide assistance in the development of all regional emergency medical services systems throughout the State.

The second program concerns the day-to-day operations of the regional emergency medical services systems. Using grant funds made available through the State agency, regional organizations determine

their needs and set their priorities in a manner consistent with State objectives and the Federal requirements for emergency medical services systems. Decisions pertaining to the implementation of the 15 legislative requirements are worked out between the State agency and the developing organization. For example, the State may have responsibility for conducting a statewide public education and information program, setting up training programs for emergency medical services personnel, establishing an evaluation mechanism, and developing and coordinating an emergency medical services communications system. The remaining requirements would then be the responsibility of the regional organization.

Mr. MICHEL. Thank you.

Mr. FLOOD. Mr. Conte?

PUBLIC HEALTH SERVICE BUDGET

Mr. CONTE. Dr. Cooper, as a health professional, are you satisfied and comfortable with this budget?

Dr. COOPER. I am satisfied that this is a good budget when viewed in the context of our current economic climate. Given the President's directive to minimize the Federal deficit and given the resulting policy of fiscal constraint, there were some rather severe limits placed on the size of this year's health budget.

As I mentioned earlier, we have to view this particular request within the context of the entire budget being proposed by the President. There have been significant changes in funding directly related to the health of the American people during this period of economic hardship. The health of our Nation depends not only on the availability of health services and research breakthroughs, but on the basic human requirements for food, shelter, clothing, and gainful employment. As a health professional, I can understand the need for a limited time to redirect our national resources to meet other aspects of the human condition that have a direct bearing on people's health, such as increased outlays directed towards reducing the hardships caused by unemployment.

Mr. CONTE. Many people have charged that the health budget is more the result of political and economic priorities than of medical and scientific priorities. Do you have any comment on that?

Dr. COOPER. As I mentioned earlier in a response to a question by Mr. Nacher, there are three major factors involved in the decisions affecting the allocation of health funds: first, the size of the problem; second, the public's perception of the importance of the problem; and third, the scientific opportunity that is available. I think the budget reflects all three of these factors.

As you know, Mr. Conte, we have a rather well-defined and well-established system for determining the scientific merit of various proposals. This is basically the peer-review process, of which you are familiar, by which we judge the scientific opportunity that is available in various scientific disciplines. But what is found to be of value from a scientific or medical viewpoint has to be judged also in light of the

economic realities that confront us. As part of Federal establishment, we are responsible for following the President's guidance in this area. We are also responsible, as part of the political process, for presenting our recommendations to you for your consideration as elected representatives of people. In the final analysis, it's the mixture of these factors and forces that determines what portion of our national resources will be directed toward health in 1976.

Mr. CONTE. Dr. Cooper, I know that you came into this position right before the budget came out. Are there any areas which you feel might have received greater priority in the health field? Any that might have received less priority?

Dr. COOPER. Because of the unusual tight fiscal constraints affecting the size of this year's budget, I would have to say that all of the items we are proposing are of high priority. It is a very tight budget and we had to limit what we propose to do to those areas having the highest priority. As you probably know, I was Deputy Assistant Secretary for Health during the time the fiscal year 1976 forward plan and the budget were developed. I took an active part in this process. As I mentioned to Mr. Flood earlier, there were five themes emphasized in the forward plan: continued support of research, modernization of the health statistics system, emphasis on prevention, emphasis on quality assurance, and preparation for national health insurance. I believe that these are still the items deserving highest priority.

ROLE OF OMB

Mr. CONTE. Dr. Cooper, your predecessor, Dr. Edwards, said when he resigned that the OMB had shattered his plans to consolidate health planning, budgeting, and management in the 1976 budget. I know that this may be a sensitive area, but would you care to comment on the role of OMB on the health budget? How much impact does OMB have on the allocation of funds within the general health budget?

Dr. COOPER. As you are well aware, Mr. Conte, all budget requests from Federal agencies are reviewed in considerable detail by OMB. In advising the President, the OMB has a legitimate role in balancing off the request of all Federal agencies competing for limited Federal funds and for formulating a budget that reflects the total view of the executive branch. As a manager, I recognize and respect that role. I would like to make it clear that as a health professional I do feel that additional funds could be properly and profitably spent in the health field. However, given the current economic situation, I realize why additional Federal funding is not possible at the present time.

HEALTH MANPOWER

Mr. CONTE. In the health manpower area, could you tell us in what particular area there are and will be shortages or oversupplies of medical and paramedical personnel if present trends continue?

Dr. COOPER. The supply of health manpower has been increasing rapidly in recent years, both in absolute numbers and in relation to population, and is expected to continue to increase in the years ahead.

For example, the ratio of active registered nurses increased from about 300 per 100,000 population in 1963 to over 400 per 100,000 in 1973. The increase in allied health workers has been especially rapid and vacancies for these workers in hospitals, which are the largest employers of allied health workers, have decreased.

In the health professions, where the training period is long and expensive, the increases have not been as great. However, the ratio to population of active M.D.'s increased from 135 to 151 per 100,000 in the last 10 years and will probably continue to increase as the effect of the larger entering medical school classes of the 1960's and 1970's moves into the pool of active physicians. By 1985, the ratio of physicians to population may reach 220 per 100,000.

Even with greatly increased number of active physicians, however, there will continue to be geographic areas in the country—mainly sparsely settled rural areas and urban ghettos—with an inadequate supply of physcians in relation to population. Also if present trends toward specialization continue unchecked, there could be a severe shortage of primary care and family physicians.

Mr. CONTE. What do you suggest we do about this situation of both specialty and geographic maldistribution of health manpower?

Dr. COOPER. In the past, policies to resolve these issues have concentrated mainly on increasing the aggregate supply of health manpower. I think these policies have proven to be extremely expensive and largely ineffective.

To address these problems in a more effective way, we propose to target support on distribution through special project funding and service scholarships. These projects will be at both the professional and postprofessional training levels and will include incentives for both students and institutions.

EFFECT OF NATIONAL HEALTH INSURANCE

Mr. CONTE. What do you foresee as the effect that a national health insurance system would have on the need for health manpower? Is there any way of knowing what particular areas of health care might have greater demand under a health insurance system?

Dr. COOPER. In terms of total health manpower, increased demand as a result of national health insurance could be satisfied by present and anticipated growth in the number of health professionals. For example, the number of physicians has increased by 26 percent in the last 10 years and is expected to increase by another 33 percent by 1980. Similar growth is occurring in the other health professions. In contrast to these increases, coverage under NHI should increase by only about 8 percent for all services including increases of 3 percent for inpatient services, 9 percent for ambulatory care services, and 10 percent for physicians' services.

Under NHI, there still would be selective and important shortages in underserved areas just as there are today. We are presently attempt-

ing to reduce or eliminate these shortages through outher programs. A comprehensive health insurance plan may also serve to reduce shortages in underserved areas by providing an economic incentive to health providers to enter such areas.

EVALUATION STUDY

Mr. CONTE. Last year we were told that your office was developing an evaluation study to assess the implementation of PHS activities on the regional level. This was supposed to facilitate and monitor the process of decentralization. Is the study completed? Can you give us a status report on that?

Dr. COOPER. The evaluation strategy to assess the implementation of PHS activities in the regional offices is focused primarily on the now institutionalized regional health administrators' work program. This system provides for a quarterly review and management conference with the PHS central office agencies and the assistant secretary for health and allows for the ongoing analysis of the status of decentralized PHS program. The office of regional operations within the office of the assistant secretary for health also conducts periodic management reviews of the overall operations and stewardship function of the regional offices. In addition, each of the health agencies conducts evaluations of its decentralized program.

PREDOCTORAL FELLOWSHIP PHASEOUT

Mr. CONTE. Is your general approach still one of phasing out predoctoral fellowship programs? Can you justify that?

Dr. COOPER. In the 1960's, biomedical research grants grew at an average of about 22 percent annually. In the context of such rapid growth, a large amount of research training support was provided to attract and educate an increasing number of qualified individuals in a short period of time. However, the aggregate employment patterns, the training capacity, and the numbers of qualified researchers available for the conduct of research in the mid-1970's are quite different. Institutional training capacity and student interest have grown to the point that the total number of researchers in the biomedical and behavioral sciences approaches—and in some fields is believed by some to exceed—the level of current need.

Accordingly, we believe that Federal expenditures for research training should now be directed more specifically to supporting a limited amount of training in those disciplines and areas of research in which there is a chronic shortage of highly qualified research personnel.

We regard this training support as an investment in the health and well-being of the American people and, given both the current economic situation and the supply of researchers, there is need to make our investment choices even more prudently and efficiently than in the past.

INFANT MORTALITY

Mr. CONTE. Dr. Cooper, in your statement you referred to the unacceptably high infant mortality rate in this country. Would you outline for me the various health agencies which conduct programs in this area? Would you consider this a high-priority problem?

Dr. COOPER. The factors which impinge on the problem of infant mortality are so numerous that many agencies of the Department could be said to have a role. While health programs impact most directly on the problem, education, income, nutrition before and during childbearing years, social services, and many other areas of Department responsibility have an ancillary role in the overall approach to reducing infant mortality.

Programs most directly involved in this area are those delivering health services to mothers and infants and conducting research on pregnancy and infancy. In the Health Services Administration, the Bureau of Community Health Services oversees operations of programs in maternal and child health. Direct operational responsibility for maternal and infant care (MIC) programs, children and youth (C. & Y.) programs, maternal and child health (MCH) programs, and intensive infant care (IIC) programs has been transferred to the States pursuant to sections 505(a), 508, 509, and 510 under title V of the Social Security Act. Each State must provide at least one project of each type, with funding divided between the States and the Federal Government under a specific formula. These programs have had a marked effect in reducing infant mortality where they have been in operation as categorical grant projects. The regional offices are providing technical assistance to the States in establishing and operating these programs. The Indian Health Service, also in HSA, provides comprehensive health care to a target population at high risk for infant mortality. The Office of Population Affairs and the Office for Family Planning direct programs which impact on infant mortality by enabling women to plan pregnancies and space children farther apart, and permitting women in high-risk groups (such as teenagers) to avoid pregnancy, all of which lower infant mortality. The Center for Disease Control is also a contributor to the overall effort to reduce infant mortality through the rubella immunization program and venereal disease casefinding and treatment program.

Research directed toward reducing infant mortality is conducted in both the intramural and extramural programs of most institutes of the National Institutes of Health, particularly the National Institute of Child Health and Human Development. Research focuses on improving maternal care during pregnancy and infant care at birth, and reducing perinatal and infant disease and disability. Special attention is being given to research on the sudden infant death syndrome, the largest killer of infants between 1 month and 1 year of life.

Efforts to reduce infant mortality constitute a top priority area in the health planning of the Department. The forward plan for health presently under development will include interagency cooperation to reduce infant mortality as an area for highest emphasis.

Nursing Homes

Mr. Conte. Dr. Cooper, you spoke about nursing homes in your statement. Up in Massachusetts we are having some problems because of an inadequate supply of long-term care facilities. Do you have any suggestions about what might be done in such a situation, other than building more nursing homes? Do you have any people working on alternatives to nursing home care?

Dr. Cooper. Yes; as you probably know, there has been a home health benefit under the medicare program since its inception. Similarly, a number of States have elected to offer a home health benefit under their respective State medicaid programs. Home health agencies have been shown historically to be a viable alternative to institutional care. The Public Health Service is coordinating departmental efforts directed toward promoting the increased utilization of home health services. The Public Health Service is also working with the Administration on Aging in the area of day care for the elderly and other innovative but sound alternatives to institutionalization.

Role of State, Local Government and Private Concerns

Mr. Conte. Do you honestly believe that States, local governments, and private institutions will be able to contribute a greater share toward the cost of health care delivery programs. If they can't, aren't you penalizing the health of the American people?

Dr. Cooper. We expect State and local governments and private institutions to participate to a greater extent than they have in previous years. We cannot assure that present levels of service will be maintained if State and local governments do not provide increased levels of support.

Health Planning and Resources Development Act

Mr. Conte. How much are you requesting for the implementation of the Health Planning and Resources Development Act? Isn't that less than the sum of the 1975 funding for the programs which it suspended?

Dr. Cooper. Our 1975 budget request to implement the Health Planning and Resources Development Act was $66,500,000, of which $42,200,000 was requested to support the old programs during the transition to the new planning system. This request is currently pending approval of the Congress in the Second Supplemental Appropriations Act. The 1976 budget for this activity provides $75 million to continue the implementation of the planning aspects of the act, and $100 million to initiate the resources development provisions of title XVI. So, in total, the 1976 budget actually provides more than was available for the expiring programs in the 1975 budget.

Mr. Conte. Do you think that the activities under the Health Planning and Resources Development Act will be operable in terms of the timetable provided in the act?

Dr. COOPER. The timetable set forth in the act is operable and the program is on schedule in the implementation. The designation process is progressing at the rate specified in the law. In some cases implementation will be possible prior to the specified deadlines. For example, a majority of the health system agencies will be established, conditionally designated, and funded well before June 30, 1976. In addition, a substantial number of State agencies will be established, conditionally designated, and funded before the time the act stipulates.

MEDICAL MALPRACTICE INSURANCE

Mr. CONTE. I appreciate your attention to the problem of medical malpractice insurance. Beyond Secretary Weinberger's request that companies delay precipitous action in this area, do you have any concrete suggestions as to what might be done about this problem?

Dr. COOPER. At the present time, we view the malpractice problem as primarily a State problem, unless Federal support programs cannot be served due to unavailability of providers as a consequence of unavailability of malpractice insurance.

The Federal responsibility concerns the acquisition and organization of information, especially in terms of that information required from hospital records and carriers' closed claims files. This might require some special funding. We are presently trying to estimate the cost of getting this information.

CAPITATION GRANTS

Mr. CONTE. Why are you phasing out capitation grants?

Dr. COOPER. The capitation grants provide a Federal subsidy based on the student count. Considering the economic return, say for a medical student, on his educational investment, we believe health profession students should pay a larger share of their educational costs rather than place this burden on the taxpayers. Also, capitation has been used to expand enrollment. At the present time, we no longer need to expand capacity but only maintain it. Therefore, capitation can be reduced to a lower level. We are not planning a complete phaseout of this support at this time.

NATIONAL HEALTH SERVICE SCHOLARSHIPS

Mr. CONTE. How does your funding of National Health Service scholarships compare to previous years' funding?

Dr. COOPER. In fiscal year 1974, the first year of funding, the National Health Service scholarships were funded at $3 million. In fiscal year 1975 the level is $22,500,000, the same as the fiscal year 1976 request.

Mr. CONTE. Thank you.

Mr. FLOOD. Thank you, gentlemen.

Dr. COOPER. Thank you.

TUESDAY, APRIL 8, 1975.

HEALTH SERVICES ADMINISTRATION

HEALTH SERVICES

WITNESSES

DR. ROBERT VAN HOEK, ACTING ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION
DR. PAUL B. BATALDEN, DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES
DR. MICHAEL J. GORAN, DIRECTOR, BUREAU OF QUALITY ASSURANCE
DR. HENRY E. SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH, QUALITY ASSURANCE, AND DIRECTOR, OFFICE OF PROFESSIONAL STANDARDS REVIEW
DR. ROBERT E. STREICHER, DIRECTOR, BUREAU OF MEDICAL SERVICES
W. HARELL LITTLE, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, HEALTH SERVICES ADMINISTRATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

Mr. FLOOD. We will now consider the Health Services Administration budget. Of course the committee, as you know, recognizes the fact that many of the programs in your budget lack authorizing legislation as of right now. However, we intend to proceed with the hearings, through all of these programs, on this Health Services Administration during this hearing anyhow.

Now the presentation will be made by Dr. van Hoek, the Acting Administrator of the Health Services Administration. We have a biographical sketch of yours, Doctor, which we will place in the record at this point along with any others.

BIOGRAPHICAL SKETCH

Name: Robert van Hoek, M.D.
Position: Assistant Surgeon General (08), PHS Commissioned Corps, Acting Administrator, Health Services Administration (HSA).
Birthplace and date: New York, N.Y., July 1, 1927.
Education:
1944–49, B.S., City College of New York.
1949–53, M.D., College of Physicians and Surgeons, Columbia University.
1958–59, Postgraduate Training in Radiobiology Reed College, Portland, Oreg.
Experience:
February 1975—Present—Acting Administrator, Health Services Administration.
July 1974—Present—Deputy Administrator, HSA.
January 1974—June 1974—Associate Administrator, HSA.
1972–73—Acting Director, National Center for Health Services Research and Development, Health Services and Mental Health Administration (HS).

1971–72—Deputy Administrator for Health Services Delivery, HS.
1969–71—Associate Administrator for Operations, HS.
1968–69—Director, Federal Health Programs Service, HS.
1967–68—Deputy Director, Division of Direct Health Services Public Health Service (PHS).
1967–67—Chief, Office of Research, Division of Direct Health Services, PHS.
1966–67—Action Chief, Office of Training and Research, Division of Hospitals, PHS.
1965–66—Special Assistant to Assistant Chief for Training and Research, Division of Hospitals, PHS.
1964–65—Program Specialist, General Clinical Research Center Branch, Division of Research Facilities and Resources, National Institutes of Health (NIH).
1963–4—Trainee in administrator of USPHS extramural programs, grants associates program, NIH.
1961–63—Head, Metabolism Branch of Radiation, Physiology Division, Armed Forces Radiology Research Institute, National Naval Medical Center.
1960–61—Chief, Department of Biophysics, Walter Reed Army Institute of Research.
1959–60—Nuclear Medicine Officer, Walter Reed Army Institute of Research.
1957–58—Chief, Medical and Chest Section, Wright-Patterson Air Force Base Hospital.
1954–57—Resident, Internal Medicine, Bronx VA Hospital.
1953–54—Intern, Medicine, St. Luke's Hospital, New York, N.Y.

Memberships:
Diplomate, American Board of Internal Medicine.
Fellow, American College of Physicians.
Member, American Federation for Clinical Research.
Member, Radiation Research Society.

Awards:
Michael M. Davis Lecturer, 1973.
PHS Distinguished Service Medal.
PHS Meritorious Service Medal.
Alpha Omega Alpha Honor Medical Society.

MICHAEL J. GORAN, M.D.

RÉSUMÉ

Current position: June 1973 to Present, Director, Bureau of Quality Assurance, Health Services Administration. Department of Health, Education, and Welfare.

Education:
University of Chicago, B.A., 1963.
University of Illinois, M.D., 1967.
Michael Reese Medical Center, Intern, 1967–68.
Columbia University, Resident/Fellow, 1970–73.
Board Eligible in Psychiatry, 1973.

Previous experience:
1972–73—Deputy Director, Community Health Service, Health Services and Mental Health Administration, HEW.
1970–73—Resident and Fellow, New York Psychiatric Institute, Department of Psychiatry and Division of Community and Social Psychiatry, Columbia University.
1969–70—Project Leader, Panel on Effectiveness, Secretary's Task Force on Medicaid and Related Programs, DHEW.
1968–70—Consultant on Medical Care Administration, National Institute of Mental Health DHEW.
1963–68—Research Associate and Project Coordinator, Office of Research and Medical Education, College of Medicine, University of Illinois.

Experience in Bureau of Quality Assurance, Health Services Administration, DHEW. As Director, responsible for the development, implementation, on-going administration and monitoring of the professional regulatory aspects of medicare and medicaid. Directs a bureau with 400 individuals in Washington and the 10 DHEW regional offices. Specifically responsible for the following four programs authorized by the Social Security Act:

Professional standards review organization (PSRO) program (Public Law 92–603, section 249F).

End-stage renal disease (ESRD) program (Public Law 92–603), section 299I).

Health and safety standards under medicare and medicaid (titles XVIII and XIX as amended).

Utilization review requirements (titles XVIII and XIX as amended).

Community Health Service, Health Services and Mental Health Administration, DHEW. As Deputy Director, responsible with the Director, for the development, operation, and evaluation of projects designed to provide direct health services to population groups with limited access to health care. Directed a staff of 300 individuals in Washington and the regions. Specifically responsible for the following four programs authorized under the Public Health Service Act:

Neighborhood Health Center program (Public Law 89–749, sec. 414e).

Migrant health program (Public Law 91–209).

Family Health Center program (Public Law 89–749, sec. 314e).

Grants for Public Health Services (Public Law 89–749, sec. 314d).

Panel on effectiveness, Secretary's task force on medicaid and related programs, DHEW. As project leader, directed and participated in several task groups charged with developing position papers and recommendations to: Improve the organization and delivery of health services.

Promote uniformity in standard setting and enforcement under titles XVIII and XIX of the Social Security Act.

Identify legislative changes required to improve program performance.

National Institute of Mental Health, DHEW. As the consultant on Medical Care Administration, maintained liaison between NIMH and health insurance programs, including medicare and medicaid. Provided consultation concerning quality of care, standards, benefit structure, and utilization review. Participated in studies of:

Independent practitioners under medicare.

Financing the care of the mentally ill under medicare and medicaid.

Standards for Community Mental Health Centers.

Office of Research and Medical Education, College of Medicine, University of Illinois. As research associate and project coordinator participated in the design, development, implementation, and evaluation of programs to assess the quality of patient care and improve the performance of physicians through continuing medical education. Specifically responsible for the following projects:

University Medical Center—Community hospital cooperative project designed to assist local hospitals with the design and conduct of self-evaluation and improvement programs.

Study designed to assess and improve physician responsiveness to abnormal laboratory test results.

Study designed to develop innovative approach to the evaluation of patient care.

Study designed to develop improved methods for linking continuing medical education programs to the results of medical audits.

Consultant positions:

1971–72—Office of Program Planning and Evaluation, Health Services and Mental Health Administration, Department of Health, Education, and Welfare.

1970–72—Jobs Corps Health Office, Manpower Administration, Department of Labor.

1967–71—Division of Medical Care and Hospitals, School of Hygiene and Public Health, Johns Hopkins University.

Recent speeches:

National Association of Blue Cross/Blue Shield, September 20, 1974.

American Hospital Association, June 20, 1974.

Group Health Association of America, June 12, 1974.

American Associations of Foundations for Medical Care, April 1, 1974.

American Association of Professional Standards Review Organizations, principal speaker, August 15, 1974.

New York Health Services Organization, October 9, 1974.

American Society of Oral Surgeons, Keynote speaker, October 13, 1974.

Publications:

Goran, M. J., Moga, D., "The PSRO: A Challenge for Mental Health," Psychiatric Opinion, vol. 11, No. 5, October 1974.

Gonnella, J. S., Goran, M. J., "Quality of Patient Care, A Measurement of Change—The Staging Concept," Submitted to Medical Care, September 1974.

Goran, M. J., Williamson, J. W., and Gonnella, J. S., "The Validity of Patient Management Problems," J. Med. Educ., 43:171–177, 1973.

Gonnella, J. S., Goran, M. J., Williamson, J. W., and Cotsonas, N., "The Evaluation of Patient Care—An Approach," J.A.M.A., 214:2040–2043, 1970.

Contributor, McNerney, Walter J., et al., Report of the Task Force on Medicaid and Related Programs, Washington, D.C., U.S. Government Printing Office, 1970. (Goran, Michael, project leader, medicaid task force support staff panel on effectiveness.)

Contributor, Storey, P., Williamson, J., and Castle, H. Continuing Medical Education—A New Emphasis, Chicago, American Medical Association, 1968.

Contributor, Financing Mental Health Care Under Medicare and Medicaid, Research and Statistics, Social Security Administration, U.S. DHEW, Washington, D.C., U.S. Government Printing Office, 1971 (Goran, Michael, HSMHA, NIMH staff).

Gonnella, J., Goran, M., Williamson, J. and Cotsonas, N., "Assessing Diagnostic Competence—A Proposed Model," presented at spring meeting of American Federation for Clinical Research, Atlantic City, N.J., 1967.

Project coordinator and contributor, Final Report, Continuing Medical Education Priority Projects (BSS contract PH 108–65–134), submitted March 31, 1966. John W. Williamson, M.D., project director, George E. Miller, M.D., principal investigator.

Kurowski, James L., Goran, Michael J., "Consideration of Long-Term Care in Relation to the Federal Health Programs: Medicare and Medicaid," presented at the fall meeting of American Public Health Association, Houston, Tex., 1970.

Report of the Quality Assurance Work Group, October 31, 1972—Michael J. Goran, M.D., chairman.

Report of the HS–PSRO Work Group, November 16, 1972—Michael J. Goran, M.D., Chairman.

Professional affiliations and honors: Alpha Omega Alpha, Health Service Administration Superior Service Award.

Personal background: Age 33. Health, excellent.

Mr. FLOOD. Do you have some of your people you want us to know here?

Dr. VAN HOEK. Yes, Mr. Chairman.

To my immediate right, Dr. Henry Simmons, who is the Deputy Assistant Secretary for Health, Quality Assurance, and Director of the Office of Professional Standards Review;

Dr. Robert Streicher, Director of the Bureau of Medical Services; on his right Dr. Michael Goran, Director of the Bureau of Quality Assurance; Mr. Charles Miller from the Department.

On my left is Mr. Harell Little, Office of Financial Management of Health Services Administration, and Dr. Paul Batalden, Director of the Bureau of Community Health Services.

Mr. FLOOD. I see you have a prepared statement, Doctor. How do you want to handle this?

Dr. VAN HOEK. With your permission, Mr. Chairman, I would like to read it.

Mr. FLOOD. All right. Suppose you do.

GENERAL STATEMENT

Dr. VAN HOEK. Mr. Chairman and Members of the Committee, I am pleased to have this opportunity to discuss with you the programs of the Health Services Administration and the budget request for fiscal year 1976.

Mission of Health Services

The Health Services Administration is comprised of four major organizations: the Bureau of Community Health Services, the Bureau of Quality Assurance, the Bureau of Medical Services, and the Indian Health Service. Because the appropriation request for the Indian Health Service is considered by the Interior Subcommittee, this testimony addresses the programs of the first three Bureaus.

The programs of the Health Services Administration deal with the accessibility, delivery and quality of health care available to the American people, and it is a challenge to administer such a wide range of programs which constitute a major Federal role in health and represent a collaborative effort with State and local governments and the private sector.

In order to accomplish this mission, the Health Services Administration has organized its program efforts around four strategic roles. These are: first, to place appropriate health personnel and related services in underserved areas; that is, to build primary care capacity; second, to maintain such capacity especially under those special circumstances in which it cannot be self-sustained; third, to improve the organization and efficiency of health care delivery; and fourth, to assure the quality of Federally-financed health services.

The program activities of the Health Services Administration, as currently structured, perform these roles in specific ways. The roles themselves, however, will continue to be important as we look toward the future and the implementation of national health insurance. We anticipate that our programs will help prepare the health care system for this historic legislation. Further, we anticipate that the nature of these programs will be modified during the transition period to adapt to the changing requirements for a Federal role in service delivery and quality assurance.

In 1976, in our capacity-building role, we will continue to assist the States in their implementation of 163 maternal and child health projects which are required by Public Law 93–53. Many of these projects will be initiated in late fiscal year 1975. We will be providing technical assistance to the States to assist the projects in their efforts to become fully operational and deliver services to recipients for each of the five prescribed categories. The National Health Service Corps will continue its efforts to build manpower capacity in medically underserved areas. The Corps will continue to encourage some sites to become self-sustaining and others to become independent. In the 1976 budget, we project that we will have 94 independent sites. As a result of these efforts, it is estimated that approximately 280,000 persons will be served in addition to the 600,000 persons served through federally-funded National Health Service Corps sites.

Our capacity maintenance role encompasses nearly all of the Health Services Administration categorical service grant programs as well as the direct care activities of the Bureau of Medical Services. The aggregate number of people served by these programs is in the millions, but the program significance or impact is derived from the fact that the vast majority of the people served are underserved through the usual providers of health care, such as the urban poor and migrant agricultural workers. These programs provide mechanisms for directing a flow of health care resources into areas which would not otherwise be

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served. They are essential elements in our current and future efforts to correct the geographic and socioeconomic imbalances in the delivery of health care services.

Under the role of maintaining capacity, several operational and management improvements have been and continue to be introduced in community health centers, family planning projects and migrant health projects. These improvements include the use of program indicators, uniform utilization and cost reporting systems and ambulatory health care standards. One of these improvements, program indicators or performance standards, will assist program and project management and have the effect of improving resource allocation, productivity, and the quality of health care. These efforts are essential to maintaining existing health delivery capacity during this inflationary period.

Improvement in Organization of Health Services

During 1976, the Health Services Administration will continue its development of two programs intended to foster improvement in the organization of health services. First, the health maintenance organizations program encourages the delivery of comprehensive and cost-effective health services, emphasizing prevention and ambulatory medical care. The concept on which the HMO program is based is not new—it has proven to be effective and competitive in selected situations. Our efforts are concentrated on demonstrating its effectiveness and desirability on a wide and national scale. Through 1976, we anticipate that we will have made 290 project awards for feasibility studies, planning and initial development activities and 37 loans for initial operation. Second, the emergency medical services program brings the benefits of existing technology and systems concepts to the care of patients with emergency medical problems. On a cumulative basis, the 1976 program will have provided for the development of 76 emergency medical service systems areas and will serve a potential population of 38 million persons. It is noteworthy that the legislative authorizations for both the HMO and the EMS programs require that certain funds be set aside for rural activities. Further, these programs build on the strengths of the existing health care delivery system in an overall effort to improve efficiency and effectiveness and increase the health care capacity at lowest possible increase in costs.

Quality Assurance

The fourth major role of the Health Services Administration is that of quality assurance. We have the responsibility for assuring the quality of care in the medicare, medicaid, and maternal and child health programs through a nationwide network of professional standards review organizations. Their purpose is to improve the quality and utilization of services in order to make Federal expenditures for health care services more cost effective. The PSRO's carry out this responsibility by applying the concept of peer review through a system of local physician organizations. This is a sound method for assuring quality medical care and appropriate use of health care resources and facilities. Considerable progress has been made in implementing this program in the past year. Physician acceptance has grown considerably. Over 85,000 physicians have now joined PSRO's representing more than 50

percent of the eligible physicians in their PSRO areas; and about 75 additional physician organizations are interested in obtaining Federal funds to start PSRO's in their areas. Conditional PSRO's have started, to review medicare and medicaid hospital admissions and the pace of the expansion of this review is accelerating.

There is an urgent need to assure that the 22 billion Federal dollars which will be invested in medicare and medicaid programs in 1976 be appropriately spent. Of equal importance, there is an urgent need to assure that the recipients of these programs receive quality health care. To this end, we are requesting $50 million, an increase of $14 million, to expand and strengthen the PSRO program.

The quality of care is also monitored through the medical care standards program. This regulatory activity develops, interprets, and modifies medicare and medicaid health and safety standards, as well as policies and methods for the certification of providers participating in these federally financed programs. The program is currently engaged in the development of policies for the implementation of the end-stage renal disease program which was authorized by Public Law 92–603. The medical care standards program also directly assists and strengthens federally supported State survey agencies in carrying out their provider certification functions.

In summary, Mr. Chairman, I have discussed with you four major strategic roles which we are performing through HSA's health care activities. Today we are requesting $721 million in new budget authority and trust funds. This request is $236 million less than the comparable fiscal year 1975 level. The 1976 request is based on the assumption that increased cost sharing on the part of the States, local governments, other agencies, and increased third-party reimbursements will enable services to continue at the 1975 level. This assumption results in a reduction in our 1976 request of approximately $150 million below the 1975 level. In addition, we are recommending a phaseout of the 314(d) program, which represents a reduction of $90 million. There is an increase in the request for the Professional Standards Review Organization of $14 million.

I will be happy to answer any questions the committee may have.

Comprehensive Health Grants to States

Mr. Flood. Doctor, this budget proposes a reduction of $312 million in obligations. Part of that reduction of course is your proposed elimination of the 314(d), the comprehensive health grants to the States. What kind of activities are funded by these grants that you propose to eliminate?

Dr. van Hoek. The 314(d) grants to the States support a wide range of public health activities. One activity under the law is mental health services. The law stipulates that 15 percent of the formula grant allocation must be used for support of mental health services.

In addition to that, many of the traditional public health functions of the States, such as sanitation, environmental health, disease control, including communicable diseases, food and drug inspections, and personal health services are supported under these grants to the States.

Mr. Flood. What would be the impact on the States of these individual projects if the Congress approves your request to eliminate these 314(d) programs?

Dr. VAN HOEK. On a national average the termination of this program would result in the States receiving approximately 3 to 4 percent less money for their total health budgets than they have had in the past. The 314(d) grant program contributes about 3 to 4 percent of total State health expenditures excluding mental health and the medicaid program. We have indications from some of the States that, if they are unable to obtain additional funds through other sources, they will have to cut back some of the services they have been performing.

Mr. FLOOD. How many of the States indicate that possibility?

Dr. VAN HOEK. We have had at least 88 letters from State and local health departments indicating that in one form or another they have to curtail services.

Mr. FLOOD. How many States, about?

Dr. VAN HOEK. I do not recall the exact number of States that wrote in to us.

Mr. FLOOD. When you get a chance, put that in the record. We would like to know that.

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. And the names of the States.

[The information follows:]

Dr. VAN HOEK. A total of 88 letters have been received from 28 States as follows:

Alabama (1).
Alaska (1).
Arkansas (2).
California (14).
Florida (1).
Idaho (1).
Indiana (1).
Iowa (5).
Kansas (3).
Louisiana (3).
Maryland (1).
Michigan (8).
Minnesota (9).
Missouri (7).
Montana (2).
Nevada (2).
New York (3).
North Carolina (2).
North Dakota (1).
Ohio (3).
Oklahoma (2).
Oregon (1).
Rhode Island (1).
South Carolina (1).
Texas (4).
Virginia (3).
Washington (5).
Wisconsin (1).

Mr. FLOOD. Now, that being the situation, can you identify for the committee the other sources you talk about of funds that will be available to pick up the support of the activities now funded by the 314(d) program?

Dr. VAN HOEK. There are some services that are provided which are in the area of communicable disease. There are funds available for this from the Center for Disease Control. There are also funds available under the Medicaid program, title XIX of the Social Security Act, for support of health services for individuals of low income and categorically needy and medically needy individuals.

There are also funds available through State budgets and county budgets. There are also funds available through revenue-sharing legislation and there are funds available through the Community Development Act which was recently enacted and signed into law.

Mr. FLOOD. Are the States and municipalities aware of these potentials?

Dr. VAN HOECK. Yes, sir.

Mr. FLOOD. They are?

Dr. VAN HOEK. They administer most of the other sources of funds.

Mr. FLOOD. Does this 314(d) program support any direct patient care activities? If it does, are we going to suddenly leave a lot of these people without any medical care?

Dr. VAN HOEK. The primary sources of funds for personal health services are the State and Federal matching funds for the medicaid program. In addition, there are funds available through other grants.

Mr. FLOOD. I know, but does this program support any direct patient care activities?

Dr. VAN HOEK. Yes, sir, it does.

Mr. FLOOD. If you are going to cut it out, are you going to leave a lot of people without medical care?

Dr. VAN HOEK. We are making the assumption that the other sources of funds will be able to support these services.

Mr. FLOOD. It is a little early for a yes or no answer, but suppose you try, yes or no. Is it going to leave a lot of people without any medical care if and when this takes place?

Dr. VAN HOEK. Based on the information I have from State and local governments and agencies, there will be a reduction of services.

Mr. FLOOD. The answer is "yes"?

Dr. VAN HOEK. Yes.

Mr. MILLER. Can I make this point? This is a block grant. We do not identify any of the funds for patient services. It is a State choice as to how they use the funds.

Mr. FLOOD. I know. But cut it off the top or the bottom, either way, if it is a block grant.

Mr. MILLER. It relates to your previous question.

There are a variety of sources of funds coming into State health departments and it is up to them to set their own priorities.

Mr. FLOOD. I build up the questions toward the last one. You can guess that, I suppose. Sure.

COMMUNITY HEALTH CENTERS

Now, in the Community Health Center Program you are proposing there a reduction of $41,458,000. Will all of these reductions in the Federal support be picked up by third-party insurers?

Dr. VAN HOEK. The budget is based on the assumption that the services provided by the Community Health Centers will continue, and that increased funds will be available through other sources, both from third party reimbursements and from State and local public and private agencies.

Mr. FLOOD. All of it?

Dr. VAN HOEK. Yes, sir, all of it.

Mr. FLOOD. You know last year Mr. Buzzell told us that the community health centers would recover from these sources $5.1 million of their operating budget from this third party insurance. Well, what is your experience, what has it been just of the first 9 months of this fiscal year?

Dr. VAN HOEK. Our experience in the first 9 months of this fiscal year indicates our third-party reimbursements have increased from 17 percent to 20 percent.

The proportion of Federal grant funds contributing to the support of the projects has declined from in excess of 70 percent to 69 percent.

Mr. FLOOD. All the way from 70 to 69, boy—

Drd. VAN HOEK. It was more than 70 percent.

Dr. BATALDEN. Seventy-two percent.

Dr. VAN HOEK. Seventy-two percent.

Mr. FLOOD. Buzzell told us $5.1 million. Well, you are giving me percentages. What about that $5.1 million?

Dr. VAN HOEK. The $5.1 million was attributed to expected savings due to improved project management. That is not related to third-party reimbursements. A 3 percent increase in third-party reimbursements would be approximately $12 million.

Mr. FLOOD. What is that?

Dr. VAN HOEK. The 20 percent third-party reimbursement level would result in an increase of $12 million above the 1974 level.

Mr. FLOOD. Yes.

Dr. VAN HOEK. In 1974 our reimbursements totaled $50 million. In 1975 we estimate they will total $62 million.

Mr. FLOOD. Now if the support of these other sources, whatever they are, does not materialize, what is going to happen to these community health centers, all the people they serve, what is going to happen to them?

Dr. VAN HOEK. The centers will have to make decisions on the priorities of services that they provide. At the present time, these centers provide a wide range of comprehensive health services, including social services, outreach services, health education, in some cases transportation.

Mr. FLOOD. More realignment in priority?

Dr. VAN HOEK. Some of them provide dental care. The project directors and the consumer boards will have to make some decisions as to what services are of higher priority within the total budget.

Mr. FLOOD. It is going to be tough, boys, but that is the way it is, is that right?

Dr. VAN HOEK. Within a constrained budget a health program has to make difficult management and professional decisions.

Mr. FLOOD. Something is going to get hurt under this proposal, I guess, is that it?

Dr. VAN HOEK. A certain level of services is absolutely essential to the provision of health care and to maintaining the health status of individuals. There are other services which have longer range implications in terms of their impact on health care.

In a situation where there is a restricted budget, we as health professionals tend to focus on the items that are most immediate in importance.

Mr. FLOOD. In the latter cases, all they have to do is just keep breathing, is that it?

Dr. VAN HOEK. No; we would not reach that stage, Mr. Chairman.

Mr. FLOOD. No?

MATERNAL AND CHILD HEALTH GRANTS TO STATES

All right, Doctor, you are proposing a reduction, $73 million, in the maternal and child health care program. Now, of course, a part of that reduction as far as you are concerned assumes the passage of authorizing legislation to increase these—it will increase the matching rate by grantees; is that right?

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. That is part of it. What is the status of the legislation as of today, do you know?

Dr. VAN HOEK. It is my understanding that it has been submitted to the Congress, but I am not aware that any action has been taken on that legislation to date.

Mr. FLOOD. All right. How much of the proposed $73 million reduction is related to this legislative package?

Dr. VAN HOEK. The legislative package proposed that the Federal match be decreased from an average of 50 percent to 40 percent, which would have been a 20-percent reduction in Federal contribution and a proportionate increase by the States.

The original 1975 President's budget would have permitted the States to make up that difference with that increased match.

At the present time, the difference between the 1975 budget and the 1976 budget is greater than 20 percent because the Congress added funds to the 1975 maternal and child health budget and did not approve the President's rescission proposal. Therefore, the match alone will not make up the difference, and other sources of funds, such as third party reimbursements, will have to make up the difference.

Mr. FLOOD. You do not have it in round, fat numbers?

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. $73 million in reductions, you are talking about the percentages. What about a figure? Do you have one?

Dr. VAN HOEK. The difference between the President's 1976 budget and the revised 1975 budget is $73 million.

Mr. FLOOD. All right.

Dr. VAN HOEK. Of that amount $20 million is the difference created by the congressional action on the budget in 1975. The change in the State match would make up approximately $53 million of that difference, leaving a $20 million balance to be picked up by the other sources of funds.

THIRD PARTY REIMBURSEMENTS

Mr. FLOOD. In your budget justification you state you are going to emphasize the collection in this matter of third party reimbursement. How much of that $73 million we are talking about, the reduction, how much of that $73 million reduction will be made up from this source?

Dr. VAN HOEK. Third party reimbursements, Mr. Chairman?

Mr. FLOOD. Yes.

Dr. VAN HOEK. We do not have good data on the amounts of third party reimbursement obtained in the maternal and child health program.

Mr. FLOOD. You do not?

Dr. VAN HOEK. We estimate at the present time somewhere on the order of 5 percent of the costs of the program are paid for through third party reimbursement.

The history of the Maternal and Child Health program has been one of providing services to low-income mothers and children, and in the past there have never been eligibility determination for those services and no charges made for many of the diagnostic and treatment services provided under those programs. The original intent of the legislation was not to impose an income barrier to receiving services.

Mr. FLOOD. Yes, yes. But having all that before you, knowing the vagueness, the uncertainty, lack of information, no statistics, no nothing, you still go ahead and propose your figures, feeling that this would be picked up despite all that?

Dr. VAN HOEK. In the Maternal and Child Health program the third party and private payments from the individuals are not looked to as much as the ability of the States and local public agencies to support these programs as well as access to medicaid money. Medicaid should, in many of the States, be able to financially support many of the services being provided in these programs.

Mr. FLOOD. Medicaid?

Dr. VAN HOEK. Title XIX of the Social Security Act.

Mr. FLOOD. I do not blame you for trying to hide it, with the reputation and what we knew, what you know about Medicaid now, you are going to lean with both elbows on that one?

Dr. VAN HOEK. In a number of the larger States, the Medicaid program does pay for a large amount of the services provided to low-income individuals.

Now it is true that in many other States the Medicaid program is not as comprehensive in terms of the benefits covered and the services that would be received under the Medicaid program.

Mr. FLOOD. You know all the proposals, suggestions, talk of investigations, reexamination, reconsideration of Medicaid, you know all about that, that is red hot, but despite all of that you are still going to go ahead as though there are no problems or no discussions or no concern?

Dr. VAN HOEK. Well, I think a distinction has to be made with problems of managing a program——

Mr. FLOOD. Sure.

Dr. VAN HOEK. As opposed to the potential of the program to really make a meaningful contribution in health care. The medicaid program——

Mr. FLOOD. It is like the League of Nations, sound in theory, but it just does not work; is that what you mean?

Mr. MILLER. One point about Medicaid which needs to be made is that it is an open-ended program as far as funding is concerned. If a person is eligible under the State Medicaid program for maternal and child health services, the Federal Government will match the State contribution. It is not a question of cutting back on funds. The money will be available.

Mr. FLOOD. If and when?

Mr. MILLER. No. The funds are available; while the Congress does appreciate them, the Congress always appropriates the Federal share to match legitimate State costs.

NEEDS OF MATERNAL AND CHILD HEALTH PROGRAM

Mr. FLOOD. Now, Doctor, as you know, we ordered the survey staff of this committee to study the financial needs of the maternal and child health care program, and we made a copy of that report available to you. You are not surprised if I ask you your reaction to your report, are you?

What is your reaction to the report?

Dr. VAN HOEK. My reaction to the report is that it raises a number of issues. One issue concerns the transition of the program from a combination of projects and formula grants to a total formula grant program, and the other major issue deals with the equity of the formula at the present time.

Let me speak to those two points. You will recall, Mr. Chairman, that the actual transition to a total formula grant program was postponed on two occasions from the enactment date. The reason for this delay in transition was the fact that the law in authorizing the transition created disparities in the funds that would be sent to the States. The formula is based on an urban-rural distribution with a greater weighting of the fund allocation to rural States. The project grants which were supported under that act were initiated and were targeted toward the major health problems of mothers and children and, because of the targeting, this ended up with the funds largely going to States with major metropolitan areas. In the transition period, applying the same formula, predominantly rural States received a much larger increase in dollars. The States which had received project grant money received less money than under the original combination of a project grant and formula grant program.

The Congress passed a special amendment, section 516 of title V of the Social Security Act, which then allowed us to use some money in a discretionary fashion to reallocate the funds and hold some of the States harmless that were affected.

During this period of transition and uncertainty about what the funding levels were, the program actively worked with the States, and the delay in promulgating specific regulations was based on waiting for certain decisions to be made regarding the time of the transition, and regarding what resources would be available to the States.

However, during this transition time a significant amount of program activity was directed toward working with the States, with the directors of the Maternal and Child Health programs, and the directors of the crippled children's programs. Draft guidelines were circulated and regional conferences were held. In general the States were prepared when the transition occurred.

As a case in point, we expect that all the States will have approved plans for their program of projects by the end of this fiscal year.

Mr. FLOOD. All right. But do you think that the staff is correct in stating that this Maternal and Child Health program needs more money in order to comply with these requirements of title V?

Dr. VAN HOEK. Under the current legislative authority——

Mr. FLOOD. That is what we are talking about.

Dr. VAN HOEK. Other than assuming the fact that States and local communities can provide more money, in order to adhere strictly to the legislation, more Federal funds would be required, yes, sir.

Mr. FLOOD. All right.

Crippled Children's Services

Now this Maternal and Child Health Care budget also calls—for a reduction in the support of the services for the crippled children. Now what about this?

It seems to us that the demand for these services is going to increase, as more States implement this early and periodic screening, diagnostic, treatment program, more and more and more. Am I correct in that assumption?

Dr. van Hoek. Yes, sir, that is a correct assumption.

Mr. Flood. As a matter of fact, we have information that out in Iowa the increase totaled 10 percent. Is that right?

Dr. van Hoek. That is correct, yes, sir.

Our experience to date is——

Mr. Flood. How do you put those two things together?

Dr. van Hoek. Well again, Mr. Chairman, the Crippled Children's program is part of the formula distribution to the States under title V of the Social Security Act. This current year we estimate that the Crippled Children's program will have the $65 million of Federal funds, and the States will match that to the extent of $32 million. The 1976 budget is predicated on the fact that the State and local governments and private agencies will be able to contribute more matching money to maintain the program at its current level.

Family Planning

Mr. Flood. Now, in the Family Planning program, that is another one, here again your budget proposes a reduction of $21 million.

Now your budget justification states $10.9 million will be collected from the third party reimbursements.

All right. Where is the balance going to come from?

Dr. van Hoek. The balance can be obtained from a number of sources. One is again the title XIX program, the Medicaid program which, with an approved State plan, provides that family planning services can be paid for under title XIX, and the Federal Government will contribute up to 90 percent of the costs of those services paid through title XIX.

Under the new act, family planning can be supported under funds appropriated until title XX of the Social Security Act, again with Federal matching funds.

Mr. Flood. You know, we have been here a while, we have seen these witnesses come and go like Greyhound buses. Remember, last year Dr. Shultz testified in that chair. He told us he expected the family planning program to recover 20 percent of the costs of operating the program from these third party insurance sources. But your justification that you give us here this morning indicates that there is only a 5 percent recovery. Did something funny happen on the way to the forum here, or what?

Dr. van Hoek. The current figures that I have for family planning programs indicate that the title X grant funds provide 63 percent of the total operating costs of the program.

Title XIX and IV–A of the Social Security Act provide 5.7 percent; insurance and other Federal funds, including title V, Maternal

and Child Health, 11.9 percent, and 19.4 percent are State and local funds, from other sources.

Mr. FLOOD. That is only 5 percent, not the 20 that Dr. Shultz was talking about.

Dr. BATALDEN. I think Dr. Shultz last year was referring to a different universe; that is the universe not only of the clinics that received title X support, but——

Mr. FLOOD. A different universe?

Dr. BATALDEN. Yes.

Let me define that.

The figures that Dr. van Hoek was using came from the 300 or so project grants that we support with title X funds. The figure of approximately 20 percent third-party support in organized programs for family planning that Dr. Shultz used last year referred not only to those 300 projects and 3,600 clinics in the family planning program, but as well to the hospitals, to the out-patient departments, and to the planned parenthood organizations that in fact provide those services without the benefit of title X funds. So that the figure of 20 percent really applies to the total universe of organized programs delivering family planning services.

Mr. FLOOD. I understand what you mean.

MIGRANT HEALTH

Now, Doctor, let's take a look at the migrant health program, quite a look. You know about the report which was prepared by the survey and investigations staff on this program. If I can understate it, we are very unhappy with the findings of that report, especially as they relate to the management part of the program.

Would you care to tell us what action you have taken to correct the deficiencies identified in the report?

Dr. VAN HOEK. Yes, Mr. Chairman.

We concur in essence with the recommendations that were made in that report. We have over the last several years instituted a number of corrective actions which this report addresses.

One is that the agency, and particularly Dr. Batalden's program, has worked very closely with the HEW audit agency in developing both the criteria and the procedures for identifying projects which need to be closely monitored, and evaluated prior to awards as well as following awards. We have instituted performance indicators which include——

Mr. FLOOD. I want you to go on and tell us just briefly what you are going to say now but then, for the record, by all means, in view of that report, give us in great detail a response to that report.

Dr. VAN HOEK. Yes, sir.

[The information follows:]

The committee investigations and survey staff made six specific recommendations in its report on the migrant health program. Our action plans in response to these recommendations have been forwarded to the Secretary for transmittal to the committee. The chairman should be in receipt of Mr. Weinberger's response shortly.

Mr. FLOOD. We want you to clearly identify the corrective steps that you plan, item-by-item, regarding the findings made by that report, but right now continue with your general comment. Go ahead.

Dr. VAN HOEK. Yes, sir.

In addition to the audit aspects, we have been providing technical assistance in the areas of cost accounting, financial management, and we have also instituted a specific reporting system so that we can, on an ongoing basis, monitor the performance of these projects, the first quarterly report of which will be submitted to us this spring.

In addition, along with our other ambulatory care programs, we have developed medical care standards by which we can assess the performance of these projects in delivering health services of appropriate quality.

We think that with these technical assistance activities and monitoring procedures that the performance of these projects will improve significantly.

I might add that the increase in services being provided by the projects already attests to the fact that their productivity and efficiency has increased over the last several years.

MOBILE UNITS FOR MIGRANT HEALTH CARE

Mr. FLOOD. There has been a lot of discussion going on around here about investing more money in mobile units to deliver care to the migrant worker. What is your position in this matter and why?

Dr. VAN HOEK. It is our position that the use of the mobile clinics is appropriate only in very selected situations.

At the present time, of the 105 migrant projects, some 10 use mobile clinics of one type or another. Primarily these are used for very specific types of services. They are used to provide immunization, to do certain types of disease screening such as TB screening, or to provide dental care.

The analysis that we have made of mobile operations indicates that for comprehensive health services it is not an effective way to provide services in terms of costs, utilization of manpower and facilities.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. FLOOD. Last year, just about this time, we held the very first hearings in the program known as Health Maintenance Organizations, quite some hearings. It was quite a set of hearings.

The appropriation request made at that time was for $60 million. Well, now, here you are. The appropriation request this time is $18 million. Well, what happened to the program?

Dr. VAN HOEK. You will recall that——

Mr. FLOOD. Yes, I recall.

Dr. VAN HOEK. We had some discussion with Dr. Cooper on this yesterday.

Mr. FLOOD. We did.

Dr. VAN HOEK. The HMO program has not moved as rapidly as we had anticipated, and that is for a number of reasons.

One is the nature of the enabling legislation. The Health Maintenance Organizations Act, title XIII of the Public Health Service Act, prescribes a very comprehensive health benefit package which must be provided by the health maintenance organizations that will receive support under grants, contracts or loans, and in order to qualify under the so-called dual option provision of the law.

In addition, there are legal, technical issues which have arisen in the course of implementing the legislation, particularly with regard to the dual option provision and the fact that there is still not a final policy on the relationship of the employer-employee and its effect on the labor-management negotiating processes.

We published a notice of proposed rulemaking on that regulation a month and a half ago. The comment period closed and we will now be reviewing those regulations and will have to have further discussions with the Department of Labor and the National Labor Relations Board to resolve those issues.

Mr. FLOOD. Now you know last year we were concerned about investing money in HMO's that would fail.

Well, what has been your experience in terms of HMO failure, since we last talked about this program?

Dr. VAN HOEK. Based on the experience of our original demonstration program prior to the enactment of the Health Maintenance Organizations Act, and also the experience of HMO's not under Federal support, we have developed very stringent criteria, so that at the present time we have funded less than half of the number of applicants who have requested HMO support.

Based on the stringency of the Health Maintenance Organizations Act, the criteria we use in evaluating and monitoring of the projects and the nature of the regulatory function that we will have to perform under the act, we anticipate that the failure rate will not be due to any failure of management but will be based purely on economic factors in the health marketplace.

HMO REGULATIONS

Mr. FLOOD. You mentioned regulation. Do you have all of your regulations published in final form?

Dr. VAN HOEK. No, sir, not in final form.

We have published in final form the regulations for grant and loan support; we have published as notice of proposed rulemaking the qualification and dual option regulations. The qualification regulations should be published in final form, I anticipate, within the next couple of weeks.

Mr. FLOOD. Your dual choice is still outstanding?

Dr. VAN HOEK. We are now reviewing the comments. We anticipate they will be out by about the 1st of July.

Mr. FLOOD. Well, would you say that the slowness with which you have gone about publishing the regulations has resulted in the slow growth of the program?

Dr. VAN HOEK. It would be fair to say that the complexity involved in the dual option regulations and the delay in having those final regulations has had an impact on the HMO program.

In the final analysis, based on the very critical legal and traditional issues regarding labor-management relationships, I think that the delay probably may have avoided other problems in the future.

Mr. MILLER. Mr. Chairman, before you leave HMO's, I do want to make the point that I think the comparisons in numbers should not be between $60 million and $18 million, but $40 million and $18 million,

because the $60 million figure was the 1974 appropriation which included $35 million for capitalizing a loan fund, which we do not need in 1976.

Mr. FLOOD. How much grant money have you obligated to date?

Dr. VAN HOEK. Approximately $9 million, in the grant program, and $1 million for a loan.

Mr. FLOOD. Out of $40 million in grants?

Dr. VAN HOEK. Yes; $40 million worth of grants.

BUREAU OF QUALITY ASSURANCE

Mr. FLOOD. The news media have given a lot of attention, generally, to the poor conditions of the Nation's nursing homes. What has the Bureau of Quality Assurance—quite a title—Bureau of Quality Assurance done to correct the health situation?

NURSING HOMES

Dr. VAN HOEK. The Bureau of Quality Assurance has been involved in a number of aspects of the nursing home problem. One is that it is the primary staff that develops the regulations for nursing homes. Our staff works with the professional organizations and, within the Federal Government, develops the health and safety standards which are promulgated under the medicare-medicaid program for nursing homes.

Mr. FLOOD. By the way, the budget request here does not provide for any increase, no increase at all in their budget for the Bureau of Quality Assurance, as concerned with the nursing homes.

Dr. VAN HOEK. That is correct, Mr. Chairman.

Mr. FLOOD. Are you going to have sufficient resources to adequately address this serious problem through that Bureau?

Dr. VAN HOEK. Well, to answer that question, I would have to make a point, a very important point. That is, this is not an effort which involves just the medical care standards program in the Bureau of Quality Assurance. The responsibilities that we carry out are the development and promulgation of standards.

We also are involved in the training of the State agency personnel which do the inspections. But in addition to that staff, there is a staff in the Office of the Assistant Secretary for Health, in the Office of Nursing Home Affairs, which participates in this program.

OTHER AGENCIES WITH RESPONSIBILITIES FOR NURSING HOMES

There is a program in the Health Resource Administration which has two functions; one is training of long-term care personnel, and the other is research and demonstrations on how to improve or develop alternatives to long-term institutional care. In addition, there is the staff in the Bureau of Health Insurance of the Social Security Administration and staff in the Social Rehabilitation Service, primarily in regional offices, who implement the standards. In other words, they are involved in the certification and decertification of facilities.

Also, the Administration on Aging in the Office of Secretary, has a significant role to play in the improvement of long-term care in this country.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. FLOOD. Here is one thing that stands out; you are requesting an increase of approximately $14 million for the Professional Standard Review Organization, PSRO.

Have you received applications from all of the 203 designated areas?

Dr. VAN HOEK. I would like Dr. Henry Simmons, Director of the Office of Professional Standards Review, who has asked for an opportunity to discuss the PSRO program, to respond to that question.

Dr. SIMMONS. Mr. Chairman, there are currently 105 programs under contract.

Mr. FLOOD. Have you received applications from the 203 of the designated areas?

Dr. SIMMONS. We have 105 projects under contract and we have taken an informal sounding of those who have not come in. We are under the impression that approximately 70 more would want to come in, which would make about 175. We do not have enough funds to do that, so we will be announcing the funding cycle with our present budget to bring in 20 more new planning grants in the program. But the interest in the program far exceeds the funds that we currently have available.

Mr. FLOOD. That $14 million requested increase in the PSRO's will that allow you to fund the project for all of the 203 of the PSRO areas?

Dr. SIMMONS. No, it will not.

Mr. FLOOD. It will not?

How will these PSRO's relate in their work with the Health Systems Agency to be funded under the Health Planning Act?

Dr. SIMMONS. That is being developed right now, Mr. Chairman.

The first relationship will be in area designation. We developed the criteria from the planning legislation and put together the planning and PSRO groups within our part of the health establishment to make sure that the area designations are, to the extent possible, compatible. That is the first place we are deciding to work together.

The second is in policies we are developing now, the interface——

Mr. FLOOD. What is that?

Dr. SIMMONS. The interface, where the standard setting of the PSRO will develop data useful in the health systems agencies. We do not have that developed yet. We are working on that interface, as to how they will be useful to each other.

IMPACT OF PSRO'S ON NURSING HOMES

Mr. FLOOD. What impact is this PSRO program going to have on the nursing home problem?

Dr. SIMMONS. We think it can have a substantial impact. The PSRO, as you know, is required to determine who goes into a nursing home, what care he receives, and how long he stays.

We are developing that review process right now, the criteria for it, the mechanism for it, starting with the utilization review regulations and phasing into the PSRO.

When it is up and running, it will have a substantial impact on the way the nursing homes are being used.

Public Health Service Hospitals

Mr. Flood. Doctor, does this budget propose the close-down of any of the PHS hospitals?

Dr. van Hoek. No, sir. This budget is not based on the closure of any of the Public Health Service hospitals.

Mr. Flood. Which hospitals do you plan to close?

Dr. van Hoek. At the present time we have no specific plan to close a Public Health Service hospital.

The President, in submitting the 1976 budget, indicated that a legislative proposal would be submitted to the Congress to consider closure of perhaps one or two hospitals and the current status is that we have developed criteria for examining the operation of the hospitals and a procedure for carrying out review using those criteria.

If that review indicates alternatives to the operation of a Public Health Service hospital, then that will be submitted first to the local areawide and State planning agencies, and subsequently to the Congress, as prescribed by law.

So without legislative authority, we are not in any position to close a hospital at the present time.

Mr. Flood. What is the impact of this proposed $2.7 million reduction on the requirements now in Public Law 93–155, that hospitals maintain a level of activities comparable to the level on January 1, 1973?

Dr. van Hoek. The proposed 1976 budget, if approved by the Congress, would not permit the hospitals to be in compliance with that legislative requirement.

Mr. Flood. Would not?

Dr. van Hoek. No, sir.

Emergency Medical Services

Mr. Flood. How many operational emergency medical systems do we have all the way across the United States?

Dr. van Hoek. Based on the 1974 grants that were awarded, there are 28 systems in either the planning stage or operation, covering a population of 11.5 million people.

With the 1975 budget and the awards anticipated, we would have 57 systems covering a popualtion of 28.5 million individuals.

Mr. Flood. Now take a look at page 68 of your justifications. There you have an array of statistics that are mighty impressive.

Now in the light of those statistics we are at a loss to understand the proposed reduction in the program.

Would you please explain the rationale for the cuts in terms that we can understand?

Dr. van Hoek. Mr. Chairman, the 1976 budget shows a reduction from the enacted 1975 appropriation, but is at the same level as had been proposed by the President's 1975 budget of $27 million, and subsequent reprograming reduced that to $25.1 million.

The proposal to keep the budget at the approximately $25 million level is based on the budget ceiling that is available to us and the priorities that we had to set within those total budget ceilings.

Mr. Flood. Now, on page 68, you state, and let me quote:

One State reported a 29-percent decrease in the deaths from vehicle accidents.

Now that is certainly a pretty impressive statistic.

Which State are you referring to?

Dr. VAN HOEK. That is the State of Illinois, Mr. Chairman.

Mr. FLOOD. All right.

Mr. MICHEL. What do we attribute it to?

Mr. FLOOD. Yes; I do not blame you for asking it.

Dr. VAN HOEK. Shall I respond to Mr. Michel's question?

Mr. FLOOD. Yes.

Dr. VAN HOEK. There are two factors. One is that Illinois has been one of the first States to set up a statewide emergency medical services system, which includes development of a coordinated communication system, the training of emergency medical personnel, particularly ambulance attendants to handle emergencies, and the categorization of hospitals so that patients with certain kinds of injuries or illnesses can be moved rapidly to the most appropriate site of care.

Over the last several years, while that program has been in development and operation, there has been a documented decrease in both motor vehicle accident-related deaths as well as the survival of other individuals with acute medical emergencies as well as injuries.

The second factor is that some of the further improvement in reduction in accidental deaths, at least automobile vehicles, is due to the reduction in the speed limit. We now have seen on a nationwide basis the reduction in the automobile fatalities, presumably due to the lowering of the speed limits.

COMMUNITY HEALTH CENTERS—PROJECT MANAGEMENT

Mr. MICHEL. Although this morning I heard on the news that the rate has gone up 6½ percent now, so it would indicate we have gone back to some old patterns.

You indicate that improvements in project management resulted in a decrease of 14 percent in annualized total cost per person served by the Community Health Centers, from $238 in 1974 to $206 in 1975, which is below the national per capita cost for comparable services.

How would the picture look for this year? Can we improve upon that or will that level out? Is that the best we can do? Are you expecting to hold the line by good management?

Dr. VAN HOEK. It would be hard to make a projection in terms of hard data on whether we could improve upon that. I would say that there is a potential for some further improvement but I believe the major problem at this present time would be to use that increased productivity and efficiency just to keep up with inflation.

If we can do that, I think we will have significantly increased productivity.

IMPROVED PROGRAM MANAGEMENT

Mr. MICHEL. Since you are directing the grantees to improve their project management, what steps have you taken to improve your own costs of administering the Community Health Services Administration programs?

Dr. VAN HOEK. Primarily in two areas. One is that, over the last several years, we have administered the programs with no significant increase in positions, and we have, in addition, had to continue to provide technical assistance and consultation to State and local agencies with reduced contract support funds so that we, in essence, have been doing more work with equivalent or less resources.

Mr. MICHEL. Having not hired as many or taken aboard as many individuals as you may have wanted, does that suggest you are getting more productivity out of the folks you have working in administration?

Dr. VAN HOEK. I would say yes, our productivity has increased. I would make an additional point, however, and that is that, in addition to productivity, there are certain scarce technical skills which are difficult to attract to the Federal Government and we have used consultants and contract work to supplement our own skills with the additional skills required to manage the program.

HMO PROGRAM SUPPORT

Mr. MICHEL. What is the problem in attracting those skilled people, principally?

Dr. VAN HOEK. Well, primarily in a technical area, let's say in the HMO program, one of the major skills is actuarial estimation. There are few people trained in this field to handle this type of technical problem. The competition outside in the insurance industries, the business industries, et cetera, is keen.

Mr. MICHEL. Is it salary?

Dr. VAN HOEK. Yes; they can make significantly more money than they can in the Federal Government.

COMPREHENSIVE HEALTH GRANTS TO STATES

Mr. MICHEL. In your justifications you stated that funds in the comprehensive health grants to the State programs have been used to provide immunization, to control communicable diseases, control venereal disease, and programs directed toward heart disease, cancer, and strike, to fund community mental health care and public health services.

Aren't such activities also supported by the Center for Disease Control, NIH, Alcohol, Drug Abuse, Mental Health Administration, and these other activities in Health Services Administration?

What kind of effort is there in coordinating these kinds of activities when you have the same problem being addressed by two, three, or more bureaus and programs? Isn't there a danger of duplication and overlap?

Dr. VAN HOEK. With regard to this particular formula grant program, this is a block grant to the State and the State uses these funds to supplement and complement the funds it has available from their own resources and from other Federal agencies. The States set the priorities, so that one State may use the funds for alcoholism, if it needs more money than is available through either the State budget or the alcoholism program of the National Institute of Alcoholism and Alcohol Abuse.

The communicable disease activities, such as veneral disease and tuberculosis, are closely coordinated with the Center for Disease Control. We do not directly involve ourselves in those activities. CDC has people assigned to the States. They provide technical assistance and consultation in administering the total program which includes 314(d) money and CDC money and a wide range of other funds.

So the technical, professional assistance is provided through these various programs. With alcoholism it would be the National Institute of Alcoholism and Alcohol Abuse that works with the States on how those funds are programed.

Mr. MICHEL. How do you go about coming up with a master plan? Wouldn't it be more efficient to have all the activities in a given area, under the same jurisdiction, or is that impractical?

Dr. VON HOEK. In terms of resource allocation and planning at the State level?

Mr. MICHEL. Yes.

Dr. VAN HOEK. Well, a significant amount of the program activities that we relate to at the State and local level are planned and coordinated by State local health agencies. That may not necessarily be a State health department. It may be a crippled children's agency for a particular program or it may be the commissioner of mental health and his staff when it comes to the mental health program. The coordination and integration of the services is largely a State and local function. Hopefully the new legislation, the Health Planning and Resource Development Act, which establishes health systems agencies at the local level and a State agency, will further improve that coordination and planning effort.

Mr. MICHEL. Well, I hope so.

PEDIATRIC PULMONARY CENTERS

You indicate that the largest category of chronic illness in children under 17 is chronic pulmonary disease affecting over 10 million children. Yet you are recommending no support this year for the 10 pulmonary centers which received $2 million last year. What are you anticipating will happen to these centers and why are you suggesting that the funds be cut?

Dr. VAN HOEK. We are not identifying the separate categorical activities as a line item in the budget. We are saying that there is a total budget for maternal and child health and within that total budget, in terms of the Federal Government's assistance, the State and local agencies will have to set priorities.

One of the priorities will be the trade offs between various types of services in the community. There is also, within the formula grant program, a special set-aside for projects of regional and national significance.

A portion of the funds are programed for this. The pediatric pulmonary centers will compete within that reserve as do other programs.

Mr. MICHEL. Is it desirable to expand the number of pediatric pulmonary centers? Is 10 sufficient?

Dr. VAN HOEK. We did an analysis of that for the Department which indicated that the concept of a pediatric pulmonary center which would be a resource on a State or regional basis to take care of these very complex problems and to train professional people in how to deal with

these problems is a very important concept and that we should have a regional system of more than 10 centers to effectively cover the population and the need.

It is very similar to the concept of the emergency medical services systems and the critical care units that have been established.

Mr. MICHEL. Without the grants from the Federal Government, is it not a rather dim view of any more being established in the foreseeable future?

Dr. VAN HOEK. From the standpoint of specific categorical project grant funds, I would say yes. But I think it is, again, an issue that is important and these services should be provided to individuals. There should be mechanisms for the third parties, the Medicaid program, and for the private insurance programs to pay for these services.

One problem we are leading into, a timing problem, is the fact of the consideration of national health insurance and what would be covered under that. If we do have a comprehensive national health insurance program many of the cost factors involved in these difficult decisions should be eliminated.

SUDDEN INFANT DEATH

Mr. MICHEL. What does your shop have to do with respect to the sudden infant death syndrome problem? How much is being spent in that area out of your particular budget?

Dr. VAN HOEK. This year we have $2 million identified for sudden infant death syndrome. This is being used.

Mr. MICHEL. What is the up-to-date figure on how many children are affected?

Do we have statistics there of how many have died as a result of it?

Dr. VAN HOEK. Approximately 10,000 per year.

Mr. MICHEL. One of the major goals listed under the justifications regarding the SIDS program is in reference to counseling services for families which lose a child to sudden infant death syndrome.

Why the emphasis on the family counseling? How does the sudden infant death syndrome differ from other deaths?

Dr. VAN HOEK. I will ask Dr. Batalden to answer.

Dr. BATALDEN. The services are coordinated by the maternal and Child Health program. These activities are directed toward the parents and the family affected by the sudden infant death syndrome because in managing the unexpected death of an infant, the parents and the family are oftentimes left stranded.

The parents and family of the unexpectedly dead infant bring that infant to the emergency care facility, frequently with the police raising questions about abuse or battering of the child. The emergency facility cannot treat the infant. The autopsy, when it is done, does not regularly get communicated back to the parents. Parents are left with many, many unanswered questions, a great deal of guilt, a great deal of apprehension about what they did or did not do. What this program is designed to do is to bring together at the community level all the people who touch the lives of these parents when they are confronted with this problem in an effort to develop some kind of coping mechanism to assist the parents in working through the unexpected loss of an infant.

Mr. MICHEL. Because of all the uncertainty surrounding this particular death, then I have to assume it is much more difficult for parents to rationalize as distinguished from a child suffering from any other malady or accident or whatever?

Dr. BATALDEN. Yes. The infant frequently has no specific symptoms at all. Even when the infant has recently shown signs of a slight cold and has been taken to the doctor, nothing is found that would lead them to anticipate a sudden infant death.

FAMILY PLANNING

Mr. MICHEL. Regarding the funds included for family planning services in the health services account, the Department also provides these services through medicaid and the social activities of SRS.

What is the total amount to be spent in 1976 by the Department on family planning services?

Dr. VAN HOEK. In 1976 we estimate the Department will spend approximately $223 million for family planning services.

Mr. MICHEL. How many people would we expect that to serve?

Dr. VAN HOEK. About 5 million people will be served by private physicians and in organized programs. DHEW funds will support services to this number.

Mr. MICHEL. How does that compare with 1975 in dollars and in people?

Dr. VAN HOEK. In 1975 it was—excuse me, the first figure I gave you for 1976, that should have been $195 million serving 5 million and in 1975 it was $223 million serving approximately the same number of people.

Mr. MICHEL. What does that decline in money figure suggest; that we have topped out, that is all we can do?

Dr. VAN HOEK. The net effect is due to a decrease in the funds under the family planning grants, title X that we are administering as well as a portion of the Maternal and Child Health budget. A minimum of 6 percent of our Maternal and Child Health budget is devoted to family planning. So there is a decrease in the Federal portion of the services provided under those two programs. We are assuming that the State and local health agencies will be able to pick up the differences to maintain the same number of people.

Mr. MICHEL. Are there any statistics we can tie to giving an indication of an increased amount going in that area from State and local community in the last couple of years? Rather than waste the time here, I would like to have that for the record. There may be a valid case here. The only way I can make that point to my colleagues is if we have something in the record to tie it to. I know it is the case in my own community.

Dr. VAN HOEK. I will supply the data for the record.

[The information follows:]

FAMILY PLANNING

Estimated Funding for Organized Programs - By Region and State - FY 1975
(In Thousands)

Region or State	Total	Federal			Non-Federal 1/
		Total	Direct	Indirect	
Region I Total	$8,429	$7,000	$5,074	$1,926	$1,429
Connecticut	1,262	1,049	1,027	22	213
Maine	1,201	1,009	680	329	192
Massachusetts	3,761	3,178	2,101	1,077	583
New Hampshire	933	873	447	426	60
Rhode Island	465	332	278	54	133
Vermont	807	559	541	18	248
Region II Total	34,483	30,658	13,058	17,600	3,825
New Jersey	7,830	6,990	3,490	3,500	840
New York	21,332	20,232	6,132	14,100	1,100
Puerto Rico	5,083	3,263	3,263	0	1,820
Virgin Islands	238	173	173	0	65
Region III Total	16,354	13,427	11,602	1,825	2,927
Delaware	663	425	376	49	238
District of Columbia	835	517	513	4	318
Maryland	3,054	2,409	2,155	254	645
Pennsylvania	8,259	7,148	5,715	1,433	1,111
Virginia	2,096	1,802	1,767	35	294
West Virginia	1,447	1,126	1,076	50	321
Region IV Total	36,873	31,174	25,217	5,957	5,699
Alabama	3,080	2,839	2,726	113	241
Florida	5,164	4,134	3,665	469	1,030
Georgia	5,932	4,764	3,848	916	1,168
Kentucky	4,072	3,664	3,272	392	408
Mississippi	2,373	2,184	1,934	250	189
North Carolina	4,608	4,028	3,153	875	580
South Carolina	4,460	3,386	3,334	52	1,074
Tennessee	7,184	6,175	3,285	2,890	1,009
Region V Total	24,161	20,710	19,596	1,114	3,451
Illinois	6,322	4,822	4,322	500	1,500
Indiana	2,071	1,708	1,651	57	363
Michigan	6,043	5,588	5,088	500	455
Minnesota	1,951	1,251	1,230	21	700
Ohio	6,039	5,812	5,806	6	227
Wisconsin	1,735	1,529	1,499	30	206
Region VI Total	42,326	36,698	20,000	16,698	5,628
Arkansas	3,715	3,243	2,442	801	472
Louisiana	9,366	8,366	3,866	4,500	1,000
New Mexico	1,982	1,763	1,443	320	219
Oklahoma	3,173	2,495	2,495	0	678
Texas	24,090	20,831	9,754	11,077	3,259
Region VII Total	12,485	9,884	6,966	2,918	2,601
Iowa	2,638	2,105	1,405	700	533
Kansas	1,794	1,447	1,007	440	347
Missouri	5,917	4,564	3,436	1,128	1,353
Nebraska	2,136	1,768	1,118	650	368

Region or State	Total	Federal			Non-Federal 1/
		Total	Direct	Indirect	
Region VIII Total	3,157	3,149	3,149	0	8
Colorado	1,173	1,173	1,173	0	0
Montana	585	585	585	0	0
North Dakota	330	322	322	0	8
South Dakota	327	327	327	0	0
Utah	521	521	521	0	0
Wyoming	221	221	221	0	0
Region IX Total	17,290	11,233	8,597	2,636	6,057
Arizona	890	716	714	2	174
California	13,876	8,354	6,825	1,529	5,522
Guam	99	89	89	0	10
Hawaii	1,919	1,709	638	1,071	210
Nevada	458	335	301	34	123
Trust Territory	48	30	30	0	18
Region X Total	5,413	3,419	3,217	202	1,994
Alaska	583	345	345	0	238
Idaho	521	392	369	23	129
Oregon	1,892	1,309	1,236	73	583
Washington	2,417	1,373	1,267	106	1,044

Totals may not add due to rounding

1/ Includes State, local and other funds, a large portion of which are matching funds.

Mr. MICHEL. Now you say that you are going to continue to place emphasis of information education on activities designed to reach the high-risk and hard-to-reach populations. Can you identify what you mean by high-risk populations, No. 1?

Dr. VAN HOEK. The high-risk populations are the teenagers for whom there is a significant increase in pregnancies, women over 35 years of age and families of low income and individuals who are mentally retarded or mentally incompetent.

Mr. MICHEL. You say emphasis will be given to those hard to reach. Those would fall in a different category, right?

Could you identify those more clearly?

Dr. VAN HOEK. Yes.

There are the teenagers. The adolescents are difficult to reach because they do not accept the traditional health services system. Second, there are certain segments of our population who, for cultural, social, or religious reasons, are not receptive to family planning information or services. Third, males of certain population groups are resistant to family planning concepts.

Dr. Batalden can amplify on that.

Dr. BATALDEN. Let me describe the situation with respect to teenagers. In a survey that was done, four-fifths of the sexually experienced, never married, 15- to 19-year-olds engaged in sexual intercourse without contraceptives. Three out of 10 became pregnant and 7 out of 10 for some reason thought they could not get pregnant either because they were too young or because it was the wrong time, or for a host of different reasons. But there is a basic educational gap there. This is the population that uses our regular means of health services infrequently, the adolescent population. They have turned to a variety of other means of providing clinical services, including free clinics and a variety of other mechanisms.

EFFECT OF FAMILY PLANNING ON BIRTH RATE

Mr. MICHEL. Dr. van Hoek, yesterday Dr. Cooper made mention of the decline in the birth rate in the country. Do you have any statistics that would indicate what effect the Federal Government or all of the governmental activity in the area of family planning have had on the decline of that birth rate in this country?

Dr. VAN HOEK. We have information that suggests that individuals who use family planning services and who want to space their children, in effect achieve a lower number of children, and currently the expectation on the part—particularly of the younger families—is that they will have no more than two or a little over two children on the average.

This expectation and the ability of families to reduce the number of children is clear. There is a relationship between that and the availability of family planning methods. There are other factors, however. There is a tendency on the part of individuals who have a higher education, who are at a higher level of employment and higher income, to choose a smaller family size. Also, in times of very tight economy such as we face now, people, through whatever mechanisms and methods, maintain a lower family size.

So there are these various factors but there is no question that the availability of family planning methods has made possible the choice for families.

I might point out that related to a discussion we had yesterday on infant mortality is the fact that the ability of the families to space their children and to have children in the numbers that they wish has a significant implication for the health of the mother, the health of the children. Children of smaller families tend to be better educated and have better physical health than those of larger families.

Mr. MICHEL. I would like for you to supply, for the record, some statistics on the different birth rates among various segments of the population—income level, age, race—you have them. I'm sure. That might be significant in that area.

[The information follows:]

Table I

Live Births, Birth Rates, and Fertility Rates, by Race: United States, 1950, 1955, 1960, and 1965-73

(Birth rates per 1,000 population in specified group. Fertility rates per 1,000 women aged 15-44 years in specified group)

Year	Number				Birth rate				Fertility rate			
	Total	White	All other		Total	White	All other		Total	White	All other	
			Total	Negro			Total	Negro			Total	Negro
Registered Births 1/												
1973 2/	3,136,965	2,551,030	585,935	512,597	14.9	13.9	21.9	21.5	69.2	65.3	94.3	94.3
1972 2/	3,258,411	2,655,558	602,853	531,329	15.6	14.6	22.9	22.6	73.4	69.2	100.3	100.5
1971 3/	3,555,970	2,919,746	636,224	564,960	17.2	16.2	24.7	24.5	81.8	77.5	109.5	110.1
1970 3/	3,731,386	3,091,264	640,122	572,362	18.4	17.4	25.1	25.3	87.9	84.1	113.0	115.4
1969 3/	3,600,206	2,993,614	606,592	543,132	17.8	16.9	24.4	24.0	86.5	82.4	114.8	113.6
1968 3/	3,501,564	2,912,224	589,340	531,152	17.5	16.6	24.2	23.9	85.7	81.5	114.9	114.0
1967 4/	3,520,959	2,922,502	598,457	543,976	17.8	16.8	25.0	24.9	87.6	85.1	119.8	119.7
1966 3/	3,606,274	2,993,230	613,044	558,244	18.4	17.4	26.1	25.9	91.3	86.4	125.9	125.7
1965 3/	3,760,358	3,123,860	636,498	581,126	19.4	18.3	27.6	27.5	96.6	91.4	133.9	133.9
1960 3/	4,257,850	3,600,744	657,106	602,264	23.7	22.7	32.1	31.9	118.0	113.2	153.6	153.5
Births Adjusted for Underregistration												
1955	4,097,000	3,485,000	613,000	558,251	25.0	23.8	34.5	---	118.3	113.7	154.3	---
1950	3,632,000	3,108,000	524,000	466,718	24.1	23.0	33.3	31.0	106.2	102.3	137.3	126.9

1/ Beginning 1970, excludes births to nonresidents of the United States.
2/ Based on 100 percent of births in selected States and on a 50-percent sample of births in all other States; see Sources of Data.
3/ Based on a 50-percent sample of births.
4/ Based on a 20- to 50- percent sample of births.

Table II

Total Fertility Rates, and Birth Rates, by Age of Mother: United States, 1960 and 1965-73

(Total fertility rates are the sums of birth rates by age of mother multiplied by 5. Birth rates are live births per 1,000 women in specified group, enumerated as of April 1 for 1960 and 1970 and estimated as of July 1 for all other years. Figures for age of mother not stated are distributed)

Year	Total fertility rate	Age of mother							
		Under 15 years	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years
1973 1/,2/	1,895.6	1.3	59.7	120.7	113.6	56.1	22.0	5.4	0.3
1972 1/,2/	2,021.9	1.2	62.0	131.0	118.7	60.2	24.8	6.2	0.4
1971 1/,3/	2,274.6	1.1	64.7	150.6	134.8	67.6	28.7	7.1	0.4
1970 1/,3/	2,480.0	1.2	68.3	167.8	145.1	73.3	31.7	8.1	0.5
1969 3/	2,465.0	1.0	66.1	166.0	143.0	74.1	33.4	8.8	0.5
1968 3/	2,476.8	1.0	66.1	167.4	140.3	74.9	35.6	9.6	0.6
1967 4/	2,572.6	0.9	67.9	174.0	142.6	79.3	38.5	10.6	0.7
1966 3/	2,736.1	0.9	70.6	185.9	149.4	85.9	42.2	11.7	0.7
1965 3/	2,928.0	0.8	70.4	196.8	162.5	95.0	46.4	12.8	0.8
1960 3/	3,653.6	0.8	89.1	258.1	197.4	112.7	56.2	15.5	0.9

1/Excludes births to nonresidents of the United States.
2/Based on 100 percent of births in selected States and on a 50-percent sample of births in all other States; see Sources of Data.
3/Based on a 50-percent sample of births.
4/Based on a 20- to 50-percent sample of births.

Table III

Births by Age of Father: United States, 1960 and 1965-73

(Rates are live births per 1,000 men for specified group. Figures for age of father not stated are distributed. Beginning 1970, excludes births to nonresidents of the United States)

Year	15-54 years 1/	Age of father								
		15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years	50-54 years	55 years and over
1973 3/	56.1	22.5	105.6	132.2	86.8	42.5	17.9	6.6	2.2	0.4
1972 3/	59.4	23.3	114.3	139.6	92.4	46.6	19.9	7.3	2.5	0.4
1971 4/	66.3	23.7	130.7	161.5	104.1	53.1	22.7	8.1	2.8	0.5
1970 4/	71.5	25.6	146.6	175.0	112.3	57.6	24.9	9.1	3.1	0.6
1969 4/	70.1	24.1	143.6	172.9	111.8	58.5	25.5	9.3	3.3	0.6
1967-68	---	---	---	---	---	---	---	---	---	---
1966 4/	73.5	22.1	160.7	181.7	121.0	68.2	30.6	12.0	4.2	0.8
1965 4/	77.4	20.0	163.2	193.7	131.8	73.9	34.0	13.2	4.7	0.8
1960 4/	94.8	21.5	202.2	232.6	154.2	87.4	42.6	16.7	6.2	1.0

1/ Rates computed by relating total births, regardless of age of father, to men aged 15-54 years.
2/ Rates computed by relating births to fathers under 20 years of age to men aged 15-19 years.
3/ Based on 100 percent of births in selected States and on a 50-percent sample of births in all other States.
4/ Based on a 50-percent sample of births.

Table IV

Live Births by Educational Attainment of Mother

	Years of School Completed by Mother						
	Total	0-8 Years	9-11 Years	12 Years	13-15 Years	16 Years and over	Not Stated
1973	2,235,172	144,985	521,380	987,551	305,349	216,599	59,308
1972	2,183,069	149,468	510,396	981,943	292,164	196,036	53,062
1971	2,376,612	167,950	548,452	1,084,144	314,640	200,696	60,730
1970	2,487,294	183,402	564,012	1,136,988	330,006	208,510	64,376
1969	2,250,668	176,238	516,232	1,026,324	287,958	186,314	57,602

Table V

Birth Rates by Live-Birth Order: United States, 1960 and 1965-73

(Rates are live births per 1,000 women aged 15-44 years, enumerated as of April 1 for 1960 and 1970 and estimated as of July 1 for all other years. Figures for live-birth order not stated are distributed)

Year	Total	Live-birth order						
		1	2	3	4	5	6 and 7	8 and over
1973 1/ 2/	69.2	28.8	21.1	9.8	4.5	2.2	1.8	0.9
1972 1/ 2/	73.4	29.9	21.5	10.7	5.3	2.7	2.2	1.2
1971 1/ 3/	81.8	32.1	23.2	12.5	6.4	3.3	2.8	1.5
1970 1/ 3/	87.9	34.2	24.2	13.6	7.2	3.8	3.2	1.8
1969 3/	86.5	32.8	23.4	13.4	7.4	4.0	3.5	2.0
1968 3/	85.7	32.1	22.5	13.2	7.5	4.2	3.9	2.3
1967 4/	87.6	30.8	22.6	13.9	8.3	4.8	4.5	2.7
1966 3/	91.3	31.0	22.5	14.8	9.2	5.4	5.2	3.2
1965 3/	96.6	29.8	23.4	16.6	10.7	6.4	6.0	3.7
1960 3/	118.0	31.1	29.2	22.8	14.6	8.3	7.6	4.3

1/ Excludes births to nonresidents of the United States.
2/ Based on 100 percent of births in selected States and on a 50-percent sample of births in all other States; see Sources of Data.
3/ Based on 50-percent sample of births.
4/ Based on a 20- to 50-percent sample of births.

Mr. FLOOD. Will you yield?
Mr. MICHEL. Yes.

FAMILY PLANNING SPENDING LEVELS

Mr. FLOOD. Every year we get the report on the family planning. I have here a copy of that report to the House Committee on Appropriations, the full committee, March 1975.

Now, following the interrogation of Mr. Michel on this question of family planning and the statistics you gave him in reply to his questions, do you have a copy of this report with you here?

Dr. VAN HOEK. I have it, but not with me. I have seen it.

Mr. FLOOD. I direct your attention to page 53 of that report. Here we have fiscal 1974, 305,635,000. In 1975, the estimate is 294,829,000. Now that, of course, excludes the President's proposed rescissions and you know what happened there. The 1976 estimate was 258,730,000.

Now those figures are what we have on this annual report given to the full committee on this question. How do you tie those in to what you just told Mr. Michel?

Dr. VAN HOEK. The figures I gave were budget authority. I'm not sure whether the report figures are budget authority or obligational level. Is that family planning or services?

Mr. FLOOD. Agency program, obligational authority, 1972 through 1976.

I cited to you 1974, 1976 and 1975 estimates.

Dr. VAN HOEK. Does that include all family planning or just family planning services?

Mr. FLOOD. It is population reached. The title is population research and activities.

Dr. VAN HOEK. The discrepancy could be due to the National Institute of Child Health and Human Development. There is about $50 million in the National Institute of Child Health and Human Development for population research. That could be it. We will check that out, Mr. Chairman.

[The information follows:]

The numbers which I provided are budget authority estimates for the Health Services Administration and Social and Rehabilitation Service. Funding levels which appear in the Moyer Report reflect the estimated total DHEW obligations for all family planning activities. This includes Public Health Service (Health Services Administration, Center for Disease Control, National Institutes of Health, Health Resources Administration, and Office of the Assistant Secretary for Health), Social and Rehabilitation Service, and the Office of Education.

Mr. MICHEL. Frankly, you know, this points up one of the problems I have, whether it is family planning or something else. You find these different activities here and there with a different number, but it is all one and the same.

What we are getting at here is the cold turkey question. How much is the Federal Government spending on family planning and research activities, period? Of course, then you get over in the foreign aid bill, and you have more involved over there. But we are talking about the domestic effort.

Now in HMOs, I think you have indicated that the program has not been as fast as the Department had expected for a number of reasons such as the rigidity of the benefit program, several difficulties in developing regulations and other reasons. Isn't the Department proposing legislative extension of this program with the hope that some of these difficulties may be resolved?

Dr. VAN HOEK. Yes, sir, we are.

Mr. MICHEL. What other steps are being taken to deal with the problem?

Dr. VAN HOEK. We are considering legislative proposals which would change the mandatory benefit package to a more variable one based on local factors. Secondly, we are proposing modification in the requirement of an overall community rating which has a significant impact on the premium costs of the program and the competitive nature of the program.

Those are two major changes we are proposing. When the dual option regulations are finally promulgated, we will be working with employer and employee groups to get better penetration into the market for health benefit plans.

Mr. MICHEL. You mentioned the 290 project awards for feasibility studies you will have in 1976. How much money goes into a feasibility study?

Dr. VAN HOEK. $50,000.

Mr. MICHEL. Is that a flat figure, no matter where, what or any section of the country?

Dr. VAN HOEK. That is the maximum for 1 year.

Mr. MICHEL. How are those proved out to be costwise?

What kind of variable are we talking about?

Dr. VAN HOEK. Host of the awards are in fact for that limit. Very few have been underneath that limit. That doesn't reflect the total cost of doing the feasibility study because in order to qualify for eligibility for feasibility award a number of things have to be accomplished prior to making application for the granting of the award. That is to sort out those casually interested from those seriously interested in studying the feasibility of developing an HMO.

Mr. MICHEL. You refer to your effort to identify potentially successful sponsors through regional office outreach as well as through direct contacts with various organizations.

What kind of success are you having in looking into the crystal ball; what kind of increase are you anticipating in terms of numbers?

Dr. VAN HOEK. We know that there are a large number of employers who fall under the Fair Labor Standards Act and we know there are a fair number of employee groups all of whom are interested in participating in HMO programs. This is critical to the development of an HMO. That is the market.

The only thing that is delaying their interest or willingness to participate is the final dual option regulations. The critical issue there is whether the dual option will have any disruptive effect on the collective bargaining arrangement between labor and management. That is a critical issue. The other is the qualifications which we have implemented.

The qualification of an HMO is important to the marketing of the HMO to particularly employee groups in that case as well as employers.

It was pointed out to me that up until this last funding cycle we were averaging about 50 applications per cycle. This has now gone up to 80 applications totaling $13 million for this last funding cycle in fiscal year 1975.

National Health Service Corps

Mr. Michel. How many health manpower scarcity areas have been assisted by the National Health Service Corps in securing health professionals since this program began in 1971? How many doctors, nurses, and dentists have served in such areas? Do you have any statistics on that? If you do, will you supply it for the record?

I am interested in the statistics. I want to know how many doctors, nurses, and dentists have served in such areas since the program was initiated in 1971 and of the physicians originally assigned to these communities, how many have remained in them and established private practices?

[The information follows:]

Between January 1, 1972 (when the first NHSC assignees were placed in communities) and July 1, 1974, a total of 569 assignees were recruited and placed in 235 different communities. During this 2½-year period, the 569 professionals recruited represented 380 physicians, 93 dentists, and 86 physician extenders.

During fiscal year 1975, a total of 315 additional professionals (210 physicians, 42 dentists, 53 physician extenders) have been recruited for a total of 155 communities. Of these 155 communities, 113 communities represent newly staffed communities where NHSC professionals are being placed for the first time, and 42 communities represent communities where continuing replacement NHSC staffing is planned for the next 2 years.

Of the 253 physicians placed through July 1, 1973, 54 have extended, at least for an additional year, and 38 have either established independent practices or are in their final extension year establishing a private practice capability in the sites. A total of 68 communities will have become independent as of June 30, 1975, either on the basis of National Health Service Corps assignees remaining in the site and establishing a private practice, or from NHSC recruited physicians assuming an NHSC developed practice as an independent practice.

Dr. Batalden. That is 60 sites this year that have become independent. That is a little less than one-third of the total sites we have supported. It is a pretty dramatic kind of thing.

Mr. Michel. Can we improve on it?

Dr. Batalden. We expect to.

In 1973, three sites had gone independent. In 1974, 34 sites and in 1975, a total of 68.

We expect in 1976 to have about 94 go independent.

Dr. van Hoek. Twenty-six percent of the physicians this year we expect to have remain in the community.

Mr. Michel. How many areas in this country are still in need of health professionals and currently have little or no access to them?

Dr. van Hoek. Using the manpower shortage criteria we have identified close to 1,000 communities which need either physicians or dentists. Of that number 580 are in need of physicians. As of the present time we have received applications and have approved 445 communities for assignments of either physicians or dentists.

Mr. MICHEL. How does that compare with a year or two ago?

Dr. VAN HOEK. In 1973, we had only identified 183 eligible communities. We staffed all of them.

In 1974, we had identified 681 communities and staffed 193. I might point out that the designation of such a manpower shortage area not only has an impact on eligibility for assignment of a National Health Service Corps physician, but if a health professional who has received a Federal loan decides to practice there he can have his loan forgiven on the basis of 2 to 3 years' service in that community. So it is not purely assignment of Federal staff. It is also a private initiative.

PROVIDER STATUS FOR HEALTH SERVICE PROJECTS

Mr. MICHEL. In a different area, in 1976 you expect the health services project will be reimbursed for some services by medicaid and medicare and in the past, free standing health clinics, those not affiliated with a hospital, have not been eligible for medicaid reimbursement. What does the Department plan to do to make them eligible for reimbursement in 1976?

Dr. VAN HOEK. Two things: We are proposing a legislative amendment which would give these clinics special provider status under medicare.

Mr. MICHEL. Is that legislation up here yet?

Dr. VAN HOEK. I think it is.

Mr. MILLER. I believe it was also before the previous Congress.

Mr. MICHEL. Did they have hearings before the last Congress?

Mr. MILLER. I think they had hearings. They didn't pass the legislation.

Mr. MICHEL. They have not begun this year yet.

Mr. MILLER. No.

Dr. VAN HOEK. Another approach in addition to the legislative one is that we have been working with the States and with the Social Security Administration and Social and Rehabilitation Service to get the States to recognize these clinics and services for reimbursement. We have made some progress in that regard.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. MICHEL. Turning to PSRO's, Dr. Simmons, you may want to respond here. In the testimony yesterday and again today, we have heard 86,000 physicians have joined PSRO's. How many are participating at the local level?

Dr. SIMMONS. That is what we are talking about.

Mr. MICHEL. You refer to converting a limited number of planning PSRO's to conditioning status. How limited?

Dr. SIMMONS. There are 91 in the planning stage. We will convert between 30 and 50. We are reviewing them now. The rest, those who do not convert will continue in the planning phase.

Mr. MICHEL. Have you made any concerted effort to bring more physicians into the program?

Dr. SIMMONS. The applicants themselves have, yes.

It has been fairly dramatic. In Manhattan, for instance, we got a report yesterday that about 90 percent of the eligible physicians in Manhattan have signed up for the PSRO.

Mr. MICHEL. Do you have any evidence of substantial cost savings from PSRO policing of hospital admissions and length of stay of Medicare and Medicaid patients?

Dr. SIMMONS. Yes, we do. Maybe it would be best if we submitted that in a document.

Mr. MICHEL. All right, will you supply that for the record?

[The information follows:]

An extensive monitoring system is under development and should be ready for full implementation by late June 1975. The system will enable the Department to assess the performance of PSRO's on an individual and comparative basis to determine how well they are effecting changes in utilization patterns and quality of care.

The primary source of routine program data will be the Federal reporting requirements supplemented by special studies, site visits, and information required as a part of the PSRO's initial and renewal contract application contract progress reports.

The types of data to be collected and included in Federal reports include:

For admission review—the number of cases reviewed by payment source (Medicare, Medicaid, Maternal and Child Health), the number of days initially assigned and number of cases referred to physician advisers.

For continued stay review—the number of cases reviewed by payment source, the number of extensions reviewed, and the number of extensions referred to the physician adviser.

The cost data reports detail the expenditures of the PSRO by major functional activity; that is, admission review, continued stay review, criteria and standards development, profiles, medical care evaluation studies, long-term care review, ambulatory care review, and others.

For medical care evaluation studies, the PSRO is required to file quarterly reports detailing and highlighting significant problems and/or accomplishments in the topic areas studied.

Mr. MICHEL. Do the PSRO's report on the savings being made?

Dr. SIMMONS. The Federal reporting requirement is being put in now, Mr. Michel, but there are published accounts of those in the literature and nonpublished accounts. We can provide those for you along with the previously mentioned material.

Mr. MICHEL. Is there any indication of those whose hospital stays would be shortened as a result of this PSRO review?

Dr. SIMMONS. Substantial.

Mr. MICHEL. Do you have statistics to back that affirmative response up?

Dr. SIMMONS. Yes.

Mr. MICHEL. Let's have those.

[The information follows:]

LENGTH-OF-STAY EXPERIENCE AND OTHER IMPACT INDICATORS

While this summary presents selected instances of reduction in lengths of stay, experience is convincing that concurrent peer review can reduce the average length of stay, although the amount of reduction may vary from location to location.

Colorado admissions program

A recenty completed study of Medicaid admissions in the Colorado program, performed over a 3-year period (1972–74) the last of which was as a PSRO, provides dramatic results. The study shows that for 1974 (the only year of full operations of the Colorado admissions program—CAP) the number of admissions

per 1,000 eligibles dropped by 10 percent. Another significant change was the number of bed-days per 1,000 eligibles which was also reduced by 10 percent. In the case of number of bed-days per 1,000 eligible, this was not only a reduction but represented the reversal of a trend, in that the previous years' increased at a rate of 5 percent. Finally, the average length of stay, the most popular indicator, leveled out. In the 3 years prior to 1974, Colorado had been experiencing about a 4-percent increase per year in average length of stay. This leveling out of length of stay is especially significant if one considers it in conjunction with the 10-percent reduction in admissions per 1,000 eligibles. It says that even with a reduction of unwarranted admissions (usually short-stay for diagnostic tests, etc.) the length of stay when only the sick were admitted, did not increase.

Multnomah Foundation for Medical Care—CONSERVE (concurrent onsite evaluation and review effort) program

A recent evaluation report on the Multnomah Foundation for Medical Care EMCRO, now an operating PSRO, provided some dramatic average-length-of-stay reductions. In that there was no baseline data, the report tracked the average length of stay by participating hospital during an 18-month period (May 1973 to Septemper 1974). Normalizing to adjust for the fact that different hospitals entered the program at different points in time, the data showed a trend reduction in average length of stay of 1.8 percent per month, a very significant reduction.

Another subsection of that analysis showed that while average length of stay and costs at three nonparticipating hospitals increased about 7 percent from one year to the next, the average length of stay (from 7.87 days to 6.98 days) and room and board cost (from $293 to $270) fell about 11 and 8 percent respectively at one Conserve site.

Experience in other review organizations

The range in documented length of stay reduction presented in the following table is from 0.3 to 2.2 days with a mean of 0.87 days. We have also had indication that concurrent review has resulted in a 1-to-3-percent reduction in unnecessary admissions. For example, the Utah PSRO has reported a 2-percent reduction.

At an estimated hospital cost of $100 per day and given about 11 million Medicare and Medicaid admissions annually, the potential savings from reduction in lengths of stay and unnecessary admissions are significant and estimated at about three times the cost of review.

LENGTH OF STAY EXPERIENCE

SITE	Length of Stay: Pre Review	Length of Stay: Post Review	Length of Stay: Δ*	Review Time Frame	Population Covered	Comments	Source
California Medi-Cal Program	6.7	6.4	-.3	8 months (May-Dec. 1970)	Public Assistance recipients under Medicaid	Covers emergency and non-emergency hospitalization. Limited to short-stay hospitalization. Evaluation method consists of comparing projected 1970 rate of admission, length of stay, and days of care with the observed rates in the unit of analysis. If the observed 1969 LOS is compared to observed 1970 LOS, the reduction is .7 days. (Note: review program not implemented til April 1970.)	Earl W. Brian, M.D.,"Government Control of Hospital Utilization." New England Journal of Medicine, June 22, 1972.
Sacramento County (CHAP)	4.7	4.4	-.3	8 months (May-Dec. 1970)	Aid to families with dependent children.	Evaluation method consists of comparing projected 1970 rate of admissions, length of stay and days of care with the observed rates for 1970 in the unit of analysis.	Earl W. Brian, M.D., "Foundation for Medical Care Control of Hospital Utilization: CHAP-A PSRO Prototype." New England Journal of Medicine, April 26, 1973.

*Δ means change

SITE	Length of Stay: Pre Review	Length of Stay: Post Review	Length of Stay: *	Review Time Frame	Population Covered	Comments	Source
New Mexico	6.3	5.6	-.7	12 months (Sept. 1971-Aug. 1972)	Medicaid population	Limited to short stay hospitalization. Comparison to observed LOS in the preceding year, May 1970-April 1971.	New Mexico and Soc. Ser. Dept. in cooperation with one New Mex. Found. for Med. Care & the Dikewood Corp. "An Evaluation of the New Mexico Medical Program", Nov. 26, 1973
Utah (UPRO)	5.1	4.6	-.5	12 months (July 1972-July 1973)	Patients covered by one participating carrier (Educators Mutual Insurance Assoc.)	Preliminary Comparison of LOS to prior 12 months experience. Detailed analysis expected in February 1975.	Correspondence with Alan R. Nelson, M.D., President of UPRO
Illinois (HASP)	7.2	6.2	-1.0	6 months (Jan.-July 1972)	Medicaid	Comparison of observ-1972 LOS for institutions with HASP review to the 1971 Ill. Dept. of Public Assistance average LOS, causing concern that units of analysis are not identical Possible measurement problems; Baseline	Bruce A. Flasher M.D., et.al. "Professional Standards Review Organizations" JAMA, March 26, 1973 "The Hospital Admission and Surveillance Program in Ill-

SITE	Length of Stay: Pre Review	Length of Stay: Post Review	Length of Stay: *	Review Time Frame	Population Covered	Comments	Source
						data includes Medicare data and certain long hospital stay diagnoses not contained in operational period.	inois." JAMA Sept. 4, 1972.
						Costs: $14/admission, $1 million for HASP program.	Stephen M. Davidson, et.al. "Professional Standards Review Organizations - A Critique." JAMA, Nov. 26, 1973.
Overlook Hospital Summit, New Jersey	14.4	12.2	-2.2	3 years (1970-1973)	Medicare	Comparison includes consolidated Medicare admissions in short stay general hospital. Progression of LOS Reduction: 1970 - 14.4 1971 - 13.8 1972 - 12.1 1973 - 12.2	Correspondence with Overlook Hospital.

Dr. VAN HOEK. The data on some of the prototype PSRO's indicated that the average length of stay could be reduced by a half a day to a day and the number of admissions could be reduced by somewhere around 1 to 3 percent.

Mr. MICHEL. What reporting is there on the assessment of quality care?

Dr. SIMMONS. I am not sure I understand the question. You are asking about the evaluation program for PSRO or what?

Mr. MICHEL. Is there an overall reporting requirement on the kind of quality care that a patient gets in this whole evaluation?

Dr. SIMMONS. Yes.

There are overall Federal reporting requirements that contain both medical and administrative cost data. Those are being implemented into the system now. A piece of that will be the uniform hospital discharge abstract which will be a universal document. Those are not fully in place yet, but we do have again isolated data like that from prototypes and some of the PSRO's that have been in operation for up to 2 years.

Mr. MICHEL. What is the status of doctor profiles or patient profiles?

Dr. SIMMONS. Again, those are probably going to be the latest things we bring under development. We do not have a lot on that yet. We have a little data but not much.

Mr. MICHEL. But there are prospects of that actually coming into being, right?

Dr. SIMMONS. Oh, yes.

Mr. MICHEL. Do you have any baseline data with which present and future costs could be compared?

Dr. SIMMONS. Yes, we have some. This is a very difficult program to evaluate. We have talked to what we think are the smartest people in the country on this issue. It is a tough, moving baseline to attack.

Mr. MICHEL. And hospitals, since they vary so much around the country, is it possible to come up with meaningful ones there?

Dr. SIMMONS. We think so and the experts tell us that they can.

Mr. MICHEL. A final question on PSRO, is there any evaluation of a doctor's individual capacity to perform in that program?

Dr. SIMMONS. Yes, that will come out of the data that is generated.

Mr. MICHEL. In a peer-review kind of situation?

Dr. SIMMONS. Yes.

Mr. MICHEL. There has been no instance of a doctor being cited in any of these areas, is there, for not coming up to a particular standard of professionalism?

Dr. GORAN. That is one of the techniques of peer review, to establish standards and assess the performance of individual physicians against those standards.

Dr. GORAN. During the process some physicians are found not to comply and education is usually tried first to improve compliance with standards and thereby improve quality.

Dr. SIMMONS. I was thrown by your term "cited." I am not sure about cited, but identified as being aberrant and identified within the system of peer review. But by "cited," I thought you meant publicly cited.

Mr. MICHEL. Thank you.

Mr. FLOOD. Mr. Natcher?

Travel Budget

Mr. Natcher. I note from your statement that notwithstanding the fact that you are reducing employment by 801 positions and 444 man-hours, you are still presenting a travel budget at about $4 million. Since you are reducing employment to this extent, why not reduce your travel budget?

Dr. van Hoek. A significant proportion of that reduction in 801 positions, 678 to be exact, are staff that are assigned to the Public Health Service hospitals and clinics. They do relatively little travel other than for limited patient-care activities and for continuing education.

The majority of the travel budget is either devoted to permanent change of station of people brought on duty or the operations of the medical program—that is transportation of patients to other medical care facilities and escort travel—and then the balance is used for the management staff in our headquarters and in the regional offices.

In that latter portion of the budget there is not a major change in the staffing. As a matter of fact, we anticipate that given the requirements of providing technical assistance and consultation and project monitoring that our travel budget is an appropriate request.

Mr. Miller. A further point. While their budget for travel is only slightly down, $11,000 that still reflects the ability to absorb greatly increased travel costs. So in fact on a percentage basis if compared with 1975, I think you would find they are down 5, 10, or maybe 15 percent.

Mr. Natcher. At this point in the record, Doctor, if you will, give us a detailed statement showing how you arrived at $4,031,000 which you are requesting for travel.

[The information follows:]

1976 TRAVEL ESTIMATES

The fiscal year 1976 estimate was based on the projected fiscal year 1975 estimate with proposed program changes planned during fiscal year 1976. An analysis of the changes is as follows:

HEALTH SERVICES ADMINISTRATION

Health Services

Analysis of Changes in Requirements

Travel
(Dollars in thousands)

1975 Total	$4,042
Increases	
Annualization of travel for 50 new positions in 1975 (1975 new positions were estimated at 50% lapse rate)	55
Travel for 18 new positions based on 50% lapse rate	18
Due to increased requirements for matching site visits in FY 1976 for NHSC	57
Subtotal	4,172
Decreases	
Due to the elimination of 10 positions in SIDS, 58 in MCH and 63 in 314(d)	93
Due to a retrenchment of the HMO Program caused by the partial absorption of mandatory increases	18
Reduction of lower priority travel in program management activities required to offset increase for NHSC	30
1976 Total	$4,031

PUBLIC HEALTH SERVICE
TRAVEL

Agency: Health Services Administration

Appropriation/Fund Title: 75-0350 Health Services

(Dollars in thousands)

	1974 Actual	1975 Revised Estimate	1976 Estimate	Change 1976 from 1975
Travel				
Permanent change of station	$201	$289	$310	+$21
Temporary duty				
Operations				
Patients and escorts	404	410	443	+33
GSA motor pool passenger vehicles	72	72	72	---
International	---	---	---	---
Other	2,705	2,714	2,603	-111
Training	158	158	168	+10
Meetings				
Domestic	223	375	411	+36
International	24	24	24	---
Home leave	---	---	---	---
TOTAL A/	$3,787	$4,042	$4,031	-$11

A/ Reflects 1976 Congressional estimates. Excludes Service and Supply Fund, Consolidated Working Fund, and reimbursable travel for Personnel Detailed to Other Agencies.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. NATCHER. Now in your statement with regard to PSRO's on page 5 you state that physician acceptance has grown considerably. Does that apply to the State of Kentucky, Doctor?

Dr. VAN HOEK. Dr. Goran?

Mr. NATCHER. I want to see if you hear the same thing I hear.

Dr. GORAN. The rate of physician acceptance in Kentucky is not as great as in other States. We currently estimate that 39 percent of all physicians in the State have joined and are members of the PSRO there.

Mr. NATCHER. Thirty-nine percent?

Dr. GORAN. Yes, sir. That is 1,362 physician members.

Mr. NATCHER. As you know, there is a move underway at this time to repeal this provision of the law. Do you hear from physicians throughout the United States? What do you hear about this?

Dr. VAN HOEK. It is my impression that the physician interest in the program has increased. There is a greater understanding of what the implications of the PSRO program are for the physicians participating in the monitoring of the programs supported by Federal funds, and their continued participation and increased participation will occur.

Based on the number of applications that we have for planning PSRO's, the interest in continued support for the statewide PSRO support centers and the demand for going to conditional status, to start beginning review of admissions, I would say there has been a significant change in the position of physicians since a year or two ago.

THIRD PARTY REIMBURSEMENTS FOR COMMUNITY HEALTH CENTERS

Mr. NATCHER. Doctor, I did not understand fully your response to the chairman's question about third party reimbursements for community health centers.

How much was received from this source in 1974?

Dr. VAN HOEK. In 1974 for community health centers, we received 17 percent in third-party reimbursement. By third-party reimbursement we mean either private insurance or medicaid and medicare.

Mr. NATCHER. Is that for 1975?

Dr. VAN HOEK. 1974.

Mr. NATCHER. What do you anticipate for 1976?

Dr. VAN HOEK. In 1975 we anticipate 20 percent and in 1976 we anticipate a continued 20 percent from the insurance aspect. We anticipate a greater cost sharing by other State and local agencies.

Mr. NATCHER. Such as what, Doctor?

Dr. VAN HOEK. State health departments, the funds available through revenue sharing and the community development funds, and also title XX of the Social Security Act in the case of family planning.

Mr. NATCHER. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

Mr. Chairman, in light of your kidding about the time you and Mr. Michel took this morning and with the time I plan to take this

afternoon, I do not think you two gentlemen are going to have to apologize to anybody.

Let me ask a couple of questions.

INDIAN HEALTH SERVICE BUDGET

I know it is not before this subcommittee, but I used to be in the Interior Subcommittee and I have retained an interest in it. What is the situation with the Indian Health Service budget? I know there are some transfers, but if you look at the identical programs which were funded under that program last year through Interior, what has happened to the budget this year?

Dr. VAN HOEK. The budget for the Indian Health Service in 1975 is $297 million. In 1976 it will increase to $311 million, for an increase of approximately $14 million. An additional 184 positions for staffing new hospitals and clinics will be added.

Mr. OBEY. Thank you.

FAMILY PLANNING

On page 13 of your justifications, I noticed you discuss family planning programs. You are reducing family planning programs by $21 million, is that right?

Dr. VAN HOEK. Yes, sir.

Mr. OBEY. What is the rationale for that?

Dr. VAN HOEK. The rationale is that the difference in the Federal contribution from 1975 to 1976 will be taken up by increased third-party reimbursement and State and local funds.

Mr. MILLER. Mr. Obey, we have to repeat again and again that there are two major sources of open-ended funding which can be devoted to family planning, both of which provide a greater percentage of Federal participation than does the program in the Health Services Administration, title IV–A of the Social Security Act and medicaid.

Mr. OBEY. What about the total amount for family planning from all the sources we know of?

Mr. MILLER. There had been a number of figures already requested for the record of the total estimate of funds going to family planning from all sources in the Federal Government.

Mr. OBEY. I raise the question simply because you recall last year we had a major fight on the question of abortion. The amendment was defeated for a variety of reasons including the fact that there had been no hearings on it.

I was going to make the point that I think the reason the amendment was defeated last year, in addition to the fact that nobody knew about it, is that it impinged upon family planning services. I would hate to think this budget this year would have the same effect.

Mr. MILLER. But that issue revolves almost entirely around medicaid and there is not a change in medicaid funding in the budget.

THIRD PARTY REIMBURSEMENTS IN COMMUNITY HEALTH CENTERS

Mr. OBEY. Following up on Mr. Natcher's question, let me ask this: Last year in the record, Mr. Flood asked a question. He said, "Are we to assume that a 20-percent collection is the top, the maximum that a Neighborhood Health Center can collect from third parties?"

Mr. Buzzell said, "Yes, that is correct."

Mr. OBEY. You are telling us today that the program assumes collection beyond the 20-percent level?

Dr. VAN HOEK. We have to distinguish between third-party reimbursement and the total cost sharing. When we use the term "third party reimbursement," we mean private insurance and public financing programs such as medicaid and medicare which run like an insurance program. In that instance, our best estimate is that the maximum reimbursement that can be achieved through those mechanisms is 20 percent. The rest of the cost sharing will have to be out of other public and private funds such as State and local tax money, non-medicaid related.

Mr. OBEY. So in effect you are going above the 20 percent in some areas?

Dr. VAN HOEK. The 20-percent maximum deals only with one portion of the cost sharing. In this fiscal year in the community health centers, 69 percent of the total operating costs of the projects was paid by the grant funds.

The other 31 percent was cost sharing, of which 17 to 20 percent was the third-party reimbursement. There are other grant funds and other budgeted funds in those programs.

Mr. OBEY. Are you absolutely confident that the centers will be able to collect the entire $31 million from third parties?

Dr. VAN HOEK. My own personal view based on information I have and information that has been given to us by the projects is that they would have a great deal of difficulty in making up the difference.

Mr. OBEY. I would certainly think so, especially given what I would expect would be increased reliance on those centers. In other words, you do not have any hard data to support the assumption that those centers can achieve that reimbursement.

Dr. VAN HOEK. No, sir, not in terms of the total cost sharing.

Mr. OBEY. Are all the centers eligible for reimbursement under various state Medicaid plans?

Dr. VAN HOEK. No, sir. There are 13 States at the present time where the clinic services are not recognized unless the project is affiliated with a hospital or the physician directly bills through medicaid.

MATERNAL AND CHILD HEALTH PROGRAM PROJECTS

Mr. OBEY. On another matter, how many States have implemented the mandated projects under the maternal and child health program?

Dr. BATALDEN. The most recent figure as of April 7, is that eight States have developed, approved, and have operating full programs of projects. By June 30, our indication as of this last Monday, is that we will have approved plans for program or projects in all 56 jurisdictions, by June 30 of this year.

Mr. OBEY. You will go from 8 to 56?

Dr. BATALDEN. This has to do with the approval process. A variety of them are in operational stages.

We have expectations which were updated last Monday on a telephone survey with each of the regional offices and all of the States so we feel confident that that estimate will be met.

Mr. OBEY. What if a State is unable to implement the five projects required under title V. Does it lose its right to receive funds under other sections?

Dr. BATALDEN. It loses its ability to receive supplemental funds under section 516, that is correct.

Mr. OBEY. What does this budget do, if anything, to assist States to comply with those provisions? Is there any money in the budget for assistance to States?

Dr. BATALDEN. In 1975 the program will be enhanced by the additional positions which the Congress made available and during this period technical assistance will be provided to the States.

Mr. OBEY. How much in terms of financial resources are you talking about?

Dr. BATALDEN. Approximately $900,000 to support those 58 additional positions.

Mr. OBEY. They will spend how much of their time assisting the States?

Dr. BATALDEN. The bulk of the time of the entire maternal and child health program is being directed toward the full implementation of the projects requirement both at the regional and central office level.

MIGRANT HEALTH

Mr. OBEY. What about Migrant Health programs. You are expecting a reduction of 4½ million to be made up by third party reimbursement.

Dr. VAN HOEK. By that and other cost sharing.

Mr. OBEY. How much of that would my grants themselves have to pick up, realistically?

Dr. VAN HOEK. At the present time the grant funds support 64 percent of the costs of the projects. Title XIX supports about 3½ to 4 percent and patient fees represent 1½ percent. The balance of 30 percent is local, State, and grant funds from other sources.

Mr. OBEY. Local and State?

Dr. VAN HOEK. Health agencies.

Mr. OBEY. Funded by local units and State units.

Dr. VAN HOEK. That is correct, yes.

Mr. OBEY. Given the revenue crunch that those States are in, how well are migrants going to fare under those circumstances?

Mr. FLOOD. Of course, you are talking about revenue sharing, too.

Dr. VAN HOEK. Yes, sir. The States have access, in addition to their own budgets and to the funds we allocate, they have access to the revenue sharing and community development money.

Mr. OBEY. But in actuality how much is devoted? My impression is that a very small amount is devoted to health care.

Dr. VAN HOEK. Of revenue sharing, 5 to 6 percent of revenue sharing money is going into health activity.

Mr. OBEY. That is not very much.

NATIONAL HEALTH SERVICE CORPS

What about the National Health Service Corps? Will you be staffing fewer sites than you were in 1974?

Dr. VAN HOEK. In 1974 we staffed 193. In 1975, by the end of 1975, we will have staffed 180. That is a result of a number of the sites becoming independent in that the Federal assignment of a physician is no longer required or the fact that those communities no longer qualify as a manpower shortage area because they do not meet the criteria. Therefore, subsequent assignment of physicians or dentists is not required.

Mr. OBEY. How many sites have you approved as being eligible?

Dr. VAN HOEK. 445.

Mr. OBEY. How many applications do you have from M.D.'s and other health professionals who are interested in the program?

Dr. VAN HOEK. As I recall we had over 9,000 inquiries from physicians and dentists but the number of people that we have been in detailed discussion with and actually looking at communities is approximately 500.

Dr. BATALDEN. The comparable figures for the last year are about 1,500 inquiries as opposed to 9,700 for this year, and about 200 physicians actively engaging us as opposed to about 500. There has been a major increase in interest.

Mr. OBEY. What percentage of physicians assigned to those sites remain?

Dr. VAN HOEK. This year we anticipate 26 percent.

Mr. OBEY. What has it been?

Dr. VAN HOEK. The year before that it was 20 percent and the year before that it was only 3 percent.

Mr. OBEY. What is your expectation about the future?

Dr. VAN HOEK. We are targeting for a retention of about 30 percent.

Mr. OBEY. What is your expectation?

Dr. VAN HOEK. For next year?

Mr. OBEY. Yes.

Dr. VAN HOEK. Well, the expectation currently is based on the July changeover which is 26 percent. The subsequent year will depend on a significant new staff of physicians and dentists. Based on the way we work with the community, the relationships and the support to the physician and the fact that we now have a special bonus pay, we anticipate that retention will improve beyond 26 percent. Also, we have a Public Health Service scholarship program which is supporting students through medical school. These physicians will be assigned to National Health Service sites and other scarcity sites such as the Indian Health Service and pay back their obligation for having been supported with a scholarship.

We estimate with that group we will have a higher retention rate than through the general recruitment.

Mr. MILLER. Mr. Obey, I think the record on the National Health Service Corps ought to note that the authority ran out last June and there was no extension enacted in the previous Congress or this Congress. So we are held at the 1974 continuing resolution level. So an obstacle that has to be removed is extension legislation before we can move ahead.

Rural Set-Aside for HMO's

Mr. Obey. How many rural HMO's have you funded?

Dr. van Hoek. Twenty-four percent of the projects thus far are rural. That is about 22 HMO grants.

Mr. Obey. That is out of how many applications?

Dr. van Hoek. Approved grants of 95; 22 out of 95.

Mr. Obey. You have approved 22 rural out of how many rural applications?

Dr. Batalden. I do not have that figure. We can get it. There have been a total of 228 applications for the first three cycles. Ninety-five awards were made out of those. We can break that out for you by rural.

[The information follows:]

Of a total of 228 applications received in the first three cycles, 41 were from rural areas. Awards were made to 23 of these (56 percent).

Mr. Obey. Is there any significant difference?

Dr. Batalden. No, there has not been.

Mr. Obey. On page 47 would you explain something to me?

I would like to ask two questions: First, what problems are you having setting up rural HMO's which are peculiar to that kind of operation?

Secondly, would you explain to me, on page 47, the middle of the page, you say:

The $15 million for grants available from this request is supplemented by $3 million in carry-over funds from the 20 percent "rural set-aside" of the fiscal year 1975 appropriation which we do not currently have plans to obligate.

I don't understand that. Why is this?

Dr. van Hoek. This fiscal year we have $25 million for grants available which were appropriated in 1974 and carried through 1975 plus an additional $15 million in the 1975 appropriation, for a total of $40 million in grants. Of that amount we anticipate not using $3 million of the 20 percent set-aside. The HMO Act provides that in a fiscal year if the 20-percent requirement for rural grants is not met, we can carry over the balance to the subsequent year and apply it either to the rural grants or if there are none available to other grants under the HMO Act.

Mr. Obey. Why don't you anticipate using it? That is my point.

Dr. van Hoek. Because the number of grants that we have funded and the dollars that we anticipate obligating will not use up all the funds that we have available. As we have indicated, this is due to several factors. One is the problem of the dual option regulations which are not yet final, but which were published, as notice of proposed rulemaking.

Mr. Obey. Are you having any problems that are peculiar to rural as opposed to other type operations?

Dr. van Hoek. Dr. Batalden.

Dr. Batalden. The major problem we have encountered is gathering together the base from which to bring together an HMO.

Marshfield Clinic

In the case of Marshfield, there is no problem, there is a solid, well-based clinic there and it is possible for them to develop a care organization that is operating very successfully.

Mr. Obey. Where do they stand?

Dr. Batalden. They have about 25,000 enrollees currently.

Mr. Obey. I mean on their eligibility for dual choice?

Dr. Batalden. With regard to their eligibility to become qualified, they are not yet qualified and have not yet made application for qualification.

The final regulations on qualification we expect out in the space of the next couple of weeks.

MCH Training Programs

Mr. Obey. On page 79, the second paragraph:

> The training program provides for multidisciplinary training to increase the health manpower with special skills for working with the crippled and multiple handicapped.

Can you explain to me how those programs differ from programs under OE, the Office of Education, and the grants which they make available?

Dr. Batalden. Yes. The Office of Education grants specifically speak to the educational personnel. These relate to the health personnel and the allied health personnel, the occupational therapists, the physical therapist.

PSRO's

Mr. Obey. On PSRO's, you mentioned in Kentucky the percentage was 36 or 39 percent of the doctors who belong. What is the situation in Wisconsin?

Dr. van Hoek. Fifty-seven percent.

Mr. Obey. What is the national average?

Dr. Goran. Nationally, about 86,000 physicians have joined PSRO's which is about 50 percent of those eligible. It is a quarter of all physicians in the Nation but only about half are in the areas with PSRO's.

Mr. Obey. I'm getting some feedback, not as much as before, I don't think, but I am getting some about concerns—I am not getting this from the medical community, I am getting this from the people who have been talking to doctors and writing in response to those conversations—raising questions about the privacy implications for individual patients. If you were in my shoes writing letters to reassure those people, what would you tell them?

Dr. Goran. In that area, the Secretary has recently approved comprehensive confidentiality policies which in essence restrict access to information under peer review to those who have a need to know. Those policies are currently being drafted and will be issued shortly as notices of proposed rulemaking. They should go a long way toward protecting the patient's privacy and provide assurances for institutions in effectuating the program.

Mr. OBEY. Can you give me an example?

Dr. GORAN. The PSRO, in order to perform a review, must have access to information relating to individual patients and physicians. The Government, on the other hand, is precluded through this policy from having access to that information so we cannot identify the individual patient or physician involved. We can only look at aggregate statistical patterns as to how well they are working so only the reviewing body has access to the individual information under these policies.

Dr. VAN HOEK. There is also other legislative authority that has implications for this question and that is the Privacy Act which sets standards for the maintenance of records.

Mr. OBEY. I wonder if you could prepare any information for me, the equivalent of a two-page letter which says, here is Joe Blow, whose case is reviewed by so and so, and outline which eyes eventually get to see his medical history.

[The information follows:]

Dear _____

Thank you for your letter of _____ concerning the confidential nature of your medical records.

There are two mechanisms in force in the PSRO program and throughout DHEW to protect the privacy and confidentiality of all data records containing personal information: (1) Policies promulgated by the Secretary/DHEW for the maintenance of confidentiality of PSRO data; and (2) the Privacy Act (P.L. 93-579) passed into law by Congress in December, 1974. The manner in which these ensure the maintenance of confidentiality and privacy in the specific case of PSRO's and in the general case of all data records containing individually identifiable information are outlined below.

Confidentiality Provisions for PSRO Data and Information

Policy specifications for confidentiality of PSRO data and information are designed to safeguard privacy rights. Patient medical data and information indicating physician patterns of practice are regarded as privileged. Access to this information outside the PSRO review system is strictly limited to that necessary for appeals and sanctions proceedings. In addition, data subjects (patients, physicians and hospitals) may access their own PSRO information to check its accuracy. For purposes of Federal and State monitoring and evaluation, authorized personnel may access data compiled on individuals whose identification is in coded form and not by name. Access to index file cross referencing codes to names shall not be granted. Furthermore, access to such information is allowed only through on-site visits to the PSROs and the information may not be removed or transmitted outside the PSRO. These restrictions guard against routine reporting and compilation of privileged data. Also, the policy prohibits storage of privileged information in a manner that constitutes a national PSRO data base.

In addition to placing restrictions on disclosure, the policy contains provisions designed to safeguard the integrity of PSRO data systems and maintain confidentiality of the information within the systems. Data collection is restricted to that necessary for PSRO review and evaluation. Identification of data subjects must be in coded form, and access logs must be maintained showing who accessed what data for what purpose. Index code files must be maintained in a secure manner. Maintaining confidentiality is regarded as an individual responsibility of those authorized to access privileged information.

The Department plans to issue proposed regulations specifying the rules governing the maintenance of confidentiality and conditions for disclosure in May. Disclosure of PSRO data and information other than as provided for in the regulations will be strictly prohibited. Any person violating the regulatory provisions shall, upon conviction, be subject to a fine of not more than $1,000 or imprisonment for not more than six months, or both, together with costs of prosecution.

Privacy Act Provisions

Since passage of the Privacy Act in late December of 1974, the Public Health Service and HSA in particular, have established administrative mechanisms and work groups for insuring compliance with the major provisions of the Act by the called for effective date of September 27, 1975. Initial administrative systems and procedures are under development within HSA for complying with the Act. The final set of systems and procedures that will be established must await development of broad guidelines from the Office of Management and Budget, specific DHEW regulations and specific technical design recommendations to be made by the National Bureau of Standards and the Civil Service Commission. The latter two

agencies are charged with providing various units of HEW with alternative automated data system design options on the preservation of confidentiality of records kept on individuals. In addition to these technical devices, the Office of the General Council of HEW will develop a set of final legal interpretations of the various provisions of the Privacy Act. In the interim, HSA is moving ahead by developing preliminary administrative procedures which will insure compliance with the basic provisions of the Act. These provisions are summarized below:

1. The Act requires that an individual be able to determine what records pertaining to him are collected, maintained or disseminated by an agency, including a record of all disclosures;

2. The Act requires that an individual be safeguarded against agency use of his record for any purpose other than the primary reason for which that record was collected;

3. The Act requires that an individual be guaranteed access to his record and be able to obtain a copy of it, to correct or amend it;

4. The Act provides that records kept on individuals are accurate, current, and have adequate safeguards against misuse;

5. The Act provides for criminal penalties for violations by an agency or its employees of any of the above provisions.

Sincerely,

Mr. FLOOD. Mr. Shriver?

PREPARATION FOR NATIONAL HEALTH INSURANCE

Mr. SHRIVER. Dr. van Hoek, would you discuss generally what shape we are in as a nation in terms of health services capacity and how prepared we are for national health insurance?

Where are the special problem areas in getting ready for such a national program?

Does your budget request address these problem areas?

Dr. VAN HOEK. We are concerned about the ability to respond to the demands resulting from national health insurance. At present, this Nation is not fully prepared for NHI since overall effective health planning, manpower and other resource allocation, and cost and quality control mechanisms are not in place.

Our first concern in terms of health services capacity has been to assure that health resources and personnel will be available so that all citizens can take advantage of the services covered by national health insurance as soon as it becomes available. To that end, the Bureau of Community Health Services, which has the principal responsibility for building capacity in underserved areas, has increased its efforts to assess accurately the large number of sites, especially rural sites, where services capacity is either nonexistent or inadequate. The National Health Service Corps, Community Health Centers, Migrant Health, and Indian Health Service are HSA programs that focus on this problem.

We are also responsible for two programs designed to improve the organizational structure of health systems; these will help us prepare for NHI. First, the emergency medical services program is developing coordinated, regionalized EMS systems to assure that urgent care is available when it is needed for all citizens without wasteful duplication of expensive personnel and equipment. Second, the health maintenance organization program links together the financing and delivery aspects of a health services system, thereby creating simultaneous incentives to maintain quality and control costs.

Another high priority in preparing for national health insurance is to develop the PSRO's so that services provided under NHI will be appropriate in scope and quality.

Finally, within the Health Services Administration, we are continuing to work with our health service delivery programs so that they can be reimbursed for services under national health insurance.

The proposed budget places greater responsibility on State and local communities and the individual citizens rather than the Federal Government in improving the organization, distribution, and delivery of health services under NHI.

INFLATION IN COST OF MEDICAL SERVICES

Mr. SHRIVER. What has been the inflation rate over the past year for the costs of health services?

How do these figures compare with the economy in general?

Dr. VAN HOEK. Detailed sector-by-sector consumer price indexes compiled by the Department of Labor show that the rise in medical

care prices in calendar year 1974 was almost identical to that for all consumer goods and services. However, very different rates of inflation were experienced for different types of medical care and the index of prices for medical services, which does not include drugs, eyeglasses and appliances, rose somewhat more rapidly than the overall Consumer Price Index.

Specifically, the price of all consumer items increased 12.1 percent from December 1973 to December 1974. Medical care prices rose 12.5 percent and medical service prices increased 13.3 percent in this period. Physician fees closely paralleled the rise in all medical service prices; they increased 13.3 percent. However, laboratory prices went up 16.2 percent and hospital service charges rose 14.2 percent. Hospital price increases were led by rises of 16.5 percent and 20.4 percent in semi-private room and operating room fees. Price increases for dental care, eyeglasses, and drugs lagged behind the change in the overall Consumer Price Index. Dental care prices increased by 11.1 percent, the price of drugs rose 6.9 percent and the price of eyeglasses, including an eye examination, increased 8.9 percent.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. SHRIVER. We have been talking about health maintenance organizations for some time now, yet you say only 37 HMO's will get loans for "initial operation" by the end of fiscal 1976. Why is it taking so long to get this going?

Dr. VAN HOEK. That 37 HMO's are projected to receive loans by the end of fiscal year 1976 is consistent with the original program projections made in the early months after the passage of the act. Organizations, to proceed from the feasibility stage to operational status, usually require 2 to 3 years. Organizations that are further developed in the prepaid health service approach don't require this long to reach operational status. However, fewer of these more experienced groups have applied than was previously anticipated.

EMERGENCY MEDICAL SERVICES

Mr. SHRIVER. How much of the emergency medical services money you are requesting is to be used for rural activities? What does the authorizing legislation direct you to do in this regard?

Dr. VAN HOEK. It is anticipated that approximately $10,678,000 will be made available for the planning and development of emergency medical services systems in rural areas. The authorizing legislation directs that not less than 20 percent of the sums appropriated for sections 1202, 1203, and 1204 of the Emergency Medical Services Systems Act shall be made available for grants or contracts which will serve rural areas. Based on our fiscal year 1976 request, the legislation requires that $4,520,000 be made available to rural areas. The act also states that special consideration shall be given to rural areas in the awarding of grants or contracts for research projects.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Mr. SHRIVER. You say that physician acceptance of professional standards review organizations has grown considerably. Have they

any choice? I have not noticed much enthusiasm for them in my district.

We have discussed this before, but since it falls under your jurisdiction, would you talk about the problems of PSRO's in rural areas and small towns. There is a special problem in smalltown hospitals which might have only one or two doctors, yet these people understandably do not want to give up their hospitals. Also, this idea that they will have to get outside opinions as to whether they are sick enough to be admitted to a hospital scares many older Americans. I know. I have heard from many of them.

Dr. VAN HOEK. The Kansas Foundation for Medical Care, the Kansas PSRO, has succeeded in recruiting as members 1,200 physicians of the 2,609 eligible, or 46 percent. We believe that this indicates substantial support for the PSRO program in Kansas.

We recognize the problem of review in rural hospitals, and are actively engaged in developing alternate review methods to meet their special needs. The PSRO's in Utah, Colorado, and Wyoming are already dealing with review in rural hospitals and we will be studying their approaches to this situation. It should be noted that it is the responsibility of the PSRO, not the hospital, to make adequate arrangements to assure sufficient physican reviewers for the conduct of PSRO review.

Federal PSRO requirements do not require patients to get an outside opinion prior to admission. Instead, upon admission their case is compared to screening criteria developed by area physicians. Cases not meeting the criteria are referred to the physician reviewer, who will either certify or deny the admission after consulting with the attending physician. Denial by the PSRO of the necessity of an admission precludes the use of Federal funds to pay for the hospital stay, but does not require discharge of the patient from the hospital.

The attending physician, the patient, or the hospital may ask for a reconsideration of a denial and the patient may also appeal a negative reconsideration decision. PSRO review is a physician peer review process and requires no action by the patient.

Mr. SHRIVER. The language proposed for this account deletes the specific amount authorized for treating the Tuskegee study participants. The justifications state it is too difficult to determine how much will be needed. Can you give any idea as to how much this is going to take? Will it be considerably higher than the $1.6 million which is earmarked in the old language?

Dr. COOPER. Attempts to furnish accurate budget estimates for the Tuskegee medical care program continue to be complicated by the nature of the population being served, as well as the various amounts of coverage provided under medicare and medicaid.

Actuarial figures which were originally obtained indicated that normally there would be a marked increase in utilization of such a program after 3 years of operation. However, this projection was based on broad national estimates and may not be applicable to this program.

As soon as the current legal issues regarding the Tuskegee syphilis study are settled, a yet to be determined number of wives and children of syphilitic participants will be added to the existing 106 study participants receiving medical care coverage. Such an addition to the program is likely to increase further the difficulty in obtaining accurate cost estimates.

This commitment to make available a program of comprehensive medical care is a long-term obligation which it is estimated will continue until the year 2011 and which will be characterized by high costs and irregular expenditure patterns.

Mr. SHRIVER. It's a small item but why do you have an increase of $26,000 for penalty mail?

Dr. VAN HOEK. The increase of $26,000 will provide for a greater utilization of the U.S. Postal Service in 1976 by the Bureau of Community Health Services.

INCREASED POSTAGE RATES

Mr. SHRIVER. You are also asking for an increase because of "increased postage rates." Is this increase anticipated in fiscal 1976?

Dr. VAN HOEK. An increase of $15,000 is contained in the 1976 budget estimates for postage rates. This increase reflects greater utilization of the U.S. Postal Service by the Public Health Service hospitals and clinics.

CONTRACT MEDICAL CARE

Mr. SHRIVER. You also have an increase of $3.1 million for contract medical care and services; tell us about that. Do these contracts have built-in inflation increases? How would this increase compare with the inflation rate for health care in general? If this one is higher, why?

Dr. VAN HOEK. The increase of $3.1 million will provide additional funds for contract medical services as follows: $1,330,000 for the patient care activity; $111,000 for the Coast Guard medical program; and $200,000 to be received as increased reimbursements from Federal agencies for the operation of the Federal employee health program. The remainder of the increase will support increased costs for supplies, $1,160,000; equipment, $270,000; and other services, $37,000.

The contracts do not have built-in inflation increases. The projection is based on a 10.9 percent rate increase for contract medical care. This estimated increase is less than the latest statistics of the Department of Labor which show that the Consumer Price Index for medical care services have increased by 14.4 percent from February 1974 to February 1975.

COMPREHENSIVE HEALTH GRANTS TO STATES

Mr. SHRIVER. You are proposing to completely eliminate funding for the section 314(d) program—the comprehensive health grants to States. Kansas loses a little more than $1 million. The only justification given for this is that it is part of the overall effort to reduce Federal outlays. The book says these funds aren't important as they account for only 4 percent of the reported expenditures of State departments of health. Is that true in each State, or is that a national percentage?

Dr. VAN HOEK. The section 314(d) funds allotted to State health departments for fiscal year 1974 were approximately 3 percent of the expenditures of State health departments excluding mental health services and medicaid for that year, as reported to the Association of State and Territorial Health Officers. The percentage for individual States range from less than 1 percent to approximately 16 percent. I will furnish a chart for the record listing state expenditures.

[The information follows:]

PRELIMINARY

Reported State Health Agency Expenditures with Amount and Percentage from 314(d) Formula Grant Funds
Fiscal Year 1974

State or Territory	Reported State Health Agency Expenditures 1/		
	Total (1)	Amount from 314(d) (2)	Percent from 314(d) (3)
Total	$2,584,288,000	$73,095,000	2.8
Alabama	19,796,000	1,384,000	7.0
Alaska	7,424,000	335,000	4.5
Arizona	24,759,000	774,000	3.1
Arkansas	12,216,000	850,000	7.0
California	796,100,000	5,739,000	0.7
Colorado	17,725,000	926,000	5.2
Connecticut	54,851,000	1,061,000	1.9
Delaware	10,252,000	407,000	4.0
District of Columbia	63,947,000	437,000	0.7
Florida	73,447,000	2,368,000	3.2
Georgia	30,046,000	1,510,000	5.0
Hawaii	54,951,000	452,000 3/	0.8
Idaho	2,989,000 3/	154,000 3/	5.2 3/
Illinois	38,105,000	3,193,000	8.4
Indiana	12,695,000	1,581,000	12,5
Iowa	7,069,000	1,072,000	15.2
Kansas	8,524,000	896,000	10.5
Kentucky	63,532,000	1,379,000	2.2
Louisiana	22,075,000	1,331,000	6.0
Maine	6,041,000	530,000	8.8
Maryland	198,288,000	1,324,000 4/	0.7
Massachusetts	67,000,000 4/	1,826,000 4/	2.7 4/
Michigan	70,158,000	2,766,000	3.9
Minnesota	10,503,000	1,360,000	12.9
Mississippi	20,156,000	1,053,000	5.2
Missouri	28,494,000	1,646,000	5.8
Montana	6,168,000	481,000	7.8
Nebraska	5,339,000	672,000	12.6
Nevada	4,002,000	388,000	9.7
New Hampshire	6,048,000	484,000	8.0
New Jersey	42,352,000	2,177,000	5.1
New Mexico	5,462,000	597,000	10.9
New York	182,205,000	5,146,000	2.8
North Carolina	27,534,000	1,982,000	7.2
North Dakota	8,658,000	430,000	5.0
Ohio	37,318,000	3,114,000	8.3
Oklahoma	14,603,000	1,065,000	7.3
Oregon	10,632,000	915,000	8.6
Pennsylvania	65,242,000	3,522,000	5.4
Rhode Island	10,875,000	537,000	4.9
South Carolina	32,999,000	1,113,000	3.4
South Dakota	4,478,000	443,000	9.9
Tennessee	50,264,000	1,504,000	3.0
Texas	70,964,000	3,357,000	4.7
Utah	7,054,000	528,000	7.5
Vermont	4,307,000	431,000	10.0
Virginia	58,395,000	1,610,000	2.8
Washington	19,917,000	1,239,000	6.2
West Virginia	17,056,000	812,000	4.8
Wisconsin	12,269,000	1,588,000	12.9
Wyoming	5,675,000	334,000 3/	5.9

State or Territory	Reported State Health Agency Expenditures 1/		
	Total	Percent from 314(d)	Percent from 314(d)
	(1)	(2)	(3)
American Samoa	5/	5/	--
Guam	2,679,000	206,000	7.7
Puerto Rico	104,999,000	1,697,000	1.2
Trust Territory	9,651,000	374,000	3.9
Virgin Islands	5/	5/	--

Footnotes:

1/ As reported by State health agencies to the Association of State and Territorial Health Officers (ASTHO) Health Program Reporting System (HPRS) for Fiscal Year 1974, rounded to thousands.

Date are preliminary. Quality edit of information reported by each State has not yet been completed.

The totals do not include local health department expenditures from local funds. Medicaid and mental health expenditures, including "15 percent" portion of 314(d) formula grant funds, have been excluded when these could be identified.

Where State health agencies have responsibility for institutions, expenditures for them are included in the totals.

2/ Represents expenditures of "85 percent" of 314(d) formula grant funds (after setting aside one percent for evaluation) made available to the State public health authorities.

3/ $300,000 of the $493,000 314(d) formula grant funds allotted to the Idaho State public health authority was used for environmental activities by the Idaho Department of Health and Welfare, the "umbrella" agency in which the State health authority is located.

4/ estimated.

5/ Not reported.

Family Planning

Mr. Shriver. You show some pretty sizable decreases for several programs based on the anticipation that the States will increase their own spending in these areas. I doubt that Congress will go along with this, but in one area, I agree with you that the States should take the primary role—that is in the family planning program. This country is not overpopulated. We heard just yesterday how much the birth rate has been declining. There are areas where family planning is needed, I realize, but it is more a local and State problem. Do you have figures on what the States are doing themselves in this area?

Dr. van Hoek. In 1975 approximately $33,619,000 of non-Federal funds will be expended for family planning purposes. Current reporting systems do not specify exactly how much is State and local. I would be glad to insert a State-by-State table which will indicate the estimated level of funding from Federal and non-Federal sources.

[The information follows:]

FAMILY PLANNING

Estimated Funding for Organized Programs - By Region and State - FY 1975
(In Thousands)

Region or State	Total	Federal			Non-Federal 1/
		Total	Direct	Indirect	
Region I Total	$8,429	$7,000	$5,074	$1,926	$1,429
Connecticut	1,262	1,049	1,027	22	213
Maine	1,201	1,009	680	329	192
Massachusetts	3,761	3,178	2,101	1,077	583
New Hampshire	933	873	447	426	60
Rhode Island	465	332	278	54	133
Vermont	807	559	541	18	248
Region II Total	34,483	30,658	13,058	17,600	3,825
New Jersey	7,830	6,990	3,490	3,500	840
New York	21,332	20,232	6,132	14,100	1,100
Puerto Rico	5,083	3,263	3,263	0	1,820
Virgin Islands	238	173	173	0	65
Region III Total	16,354	13,427	11,602	1,825	2,927
Delaware	663	425	376	49	238
District of Columbia	835	517	513	4	318
Maryland	3,054	2,409	2,155	254	645
Pennsylvania	8,259	7,148	5,715	1,433	1,111
Virginia	2,096	1,802	1,767	35	294
West Virginia	1,447	1,126	1,076	50	321
Region IV Total	36,873	31,174	25,217	5,957	5,699
Alabama	3,080	2,839	2,726	113	241
Florida	5,164	4,134	3,665	469	1,030
Georgia	5,932	4,764	3,848	916	1,168
Kentucky	4,072	3,664	3,272	392	408
Mississippi	2,373	2,184	1,934	250	189
North Carolina	4,608	4,028	3,153	875	580
South Carolina	4,460	3,386	3,334	52	1,074
Tennessee	7,184	6,175	3,285	2,890	1,009
Region V Total	24,161	20,710	19,596	1,114	3,451
Illinois	6,322	4,822	4,322	500	1,500
Indiana	2,071	1,708	1,651	57	363
Michigan	6,043	5,588	5,088	500	455
Minnesota	1,951	1,251	1,230	21	700
Ohio	6,039	5,812	5,806	6	227
Wisconsin	1,735	1,529	1,499	30	206
Region VI Total	42,326	36,698	20,000	16,698	5,628
Arkansas	3,715	3,243	2,442	801	472
Louisiana	9,366	8,366	3,866	4,500	1,000
New Mexico	1,982	1,763	1,443	320	219
Oklahoma	3,173	2,495	2,495	0	678
Texas	24,090	20,831	9,754	11,077	3,259
Region VII Total	12,485	9,884	6,966	2,918	2,601
Iowa	2,638	2,105	1,405	700	533
Kansas	1,794	1,447	1,007	440	347
Missouri	5,917	4,564	3,436	1,128	1,353
Nebraska	2,136	1,768	1,118	650	368

Region or State	Total	Federal			Non-Federal 1/
		Total	Direct	Indirect	
Region VIII Total	3,157	3,149	3,149	0	8
Colorado	1,173	1,173	1,173	0	0
Montana	585	585	585	0	0
North Dakota	330	322	322	0	8
South Dakota	327	327	327	0	0
Utah	521	521	521	0	0
Wyoming	221	221	221	0	0
Region IX Total	17,290	11,233	8,597	2,636	6,057
Arizona	890	716	714	2	174
California	13,876	8,354	6,825	1,529	5,522
Guam	99	89	89	0	10
Hawaii	1,919	1,709	638	1,071	210
Nevada	458	335	301	34	123
Trust Territory	48	30	30	0	18
Region X Total	5,413	3,419	3,217	202	1,994
Alaska	583	345	345	0	238
Idaho	521	392	369	23	129
Oregon	1,892	1,309	1,236	73	583
Washington	2,417	1,373	1,267	106	1,044

Totals may not add due to rounding

1/ Includes State, local and other funds, a large portion of which are matching funds.

National Health Service Corps

Mr. Shriver. Tell us how you get a decrease for the National Health Service Corps because of an increase in the service and supply fund. Since this program is supposed to help get health professionals into scarcity areas, I don't believe you should be cutting your recruiting efforts.

Dr. van Hoek. The $69,000 increase in the service and supply fund is the NHSC portion of an overall increase in 1976 relating to the service and supply fund. The 1976 allowance from OMB did not provide sufficient funds to meet all mandatory increases. The increase for the fund therefore had to be absorbed which resulted in a decrease in funding levels for other Corps activities.

Efforts will be made in 1976 to maintain the same recruitment effort level as in 1975.

Patient Care

Mr. Shriver. I don't understand this cut of $3.5 million for patient care. Congress put that money in to upgrade the services at the Public Health Service hospitals. That was not intended as a one-shot effort, as was the case in upgrading the facilities themselves. These are people, 393 positions. Would you discuss this?

Dr. van Hoek. As a part of economic policy, the 1975 congressional add on of $3.5 million was proposed for rescission in fiscal year 1975 and withheld in the 1976 budget request. The Department of Health, Education, and Welfare and the Office of Management and Budget have been reviewing the impact of the rescission disapproval on the fiscal year 1976 budget activities.

Coast Guard Alcoholism Program

Mr. Shriver. Have you rehabilitated all the Coast Guard alcoholics? I ask that because you are proposing to eliminate the alcoholism rehabilitation program for the Coast Guard in fiscal year 1976.

Dr. van Hoek. No. In order to meet fiscal year 1976 budget reductions in the Coast Guard medical program we plan to reduce the costs of this rehabilitation program. Instead of paying the Navy for this service, as we have been doing, we will be sending these coast guardsmen to our San Francisco Public Health Service hospital for the needed rehabilitation. Our hospital should be able to absorb this additional workload at a very minimal increase in their total operating costs.

MCH Crippled Children's Services

Mr. Shriver. What would you suggest I tell my people in Kansas about this cut for our State of about $169,000 for crippled children's services?

Dr. van Hoek. Title V of the Social Security Act provides a formula for alloting to each State a grant for crippled children's services. The formula takes into consideration the number of children under 21, the State average per capita income, and the distribution of children under 21 in rural and urban areas.

The $169,000 reduction from 1975 to 1976 occurs as a result of the President's efforts to curtail Federal spending and to minimizing the 1976 Federal budget deficit. The President has proposed that the total amount available for distribution by formula to the States be reduced, and it was through the formula provisions and the data base for Kansas on per capita income and rural and urban children that the reduction was determined.

Technical assistance is being provided and will continue during 1976 in order to assist the State health department in obtaining increased revenues from third-party reimbursement programs such as medicaid, private health insurance, and other sources. It is anticipated that these other sources of funds should offset reductions in the Federal title V support.

Mr. SHRIVER. Thank you.

Mr. FLOOD. Mr. Conte?

COMMUNITY HEALTH CENTERS

Mr. CONTE. In terms of community health centers, your justification calls for increased third-party contributions from medicaid and medicare, among others. My impression is that the administration is trying to cut down on medicaid and medicare expenditures. Is it really going to be possible to get payment for this out of the medicaid and medicare programs?

Dr. VAN HOEK. Our best estimate is that the maximum reimbursement that can be achieved through medicare and medicaid is about 20 percent which is presently being collected. Our budget request is based on increased funding from State, local, and private voluntary organizations so that we may maintain our current program service levels.

HMO DUAL OPTION PROVISION

Mr. CONTE. Recently there was an article in the Wall Street Journal concerning the requirement that employers give their workers the option of joining an HMO if they belong to another health benefit plan. Has any decision on this been made yet, and if so, what was it?

Dr. VAN HOEK. The HMO Act of 1973 (Public Law 93-222), section 1310, mandates that an employer covered by the Fair Labor Standards Act employing 25 or more employees in any calendar quarter, and offering to its employees a health benefits plan, must offer an HMO option if a qualified HMO exists in the area in which an employee resides.

A notice of proposed rulemaking regarding implementation of section 1310 was published February 1975. Final regulations are expected this summer.

SUDDEN INFANT DEATH SYNDROME

Mr. CONTE. What are you doing in the field of sudden infant death syndrome this year?

Dr. VAN HOEK. Approximately 30 grants will be made to local communities for the development of comprehensive education, counseling, and service programs. These awards will be made on a priority basis to groups seeking to serve populations of 1 million or more. In

addition, contracts were awarded for two films, one for public education and one for emergency worker education. The remaining funds will be used to support 10 full-time staff and for the development and printing of various educational materials.

Professional Standards Review Organization

Mr. Conte. What sort of progress are you having with the PSRO program? What percentage of the doctors in this country are participating? How many PSRO's do you intend to fund next year? Has there been any opportunity to evaluate the actions of the PSRO's which are not in place?

Dr. van Hoek. We have made significant progress since this time last year in implementing the PSRO program. About 86,000 physicians have become PSRO members. This represents approximately 50 percent of the eligible physicians in areas having PSRO's and about a quarter of all physicians national. Eleven conditional PSRO's and 91 planning projects were funded late in fiscal year 1974. Three additional conditional PSRO's have already been funded this fiscal year and we anticipate converting 37 planning projects to conditional status and funding up to 20 new planning projects. Approximately 50 additional organizations have expressed interest in initiating planning PSRO activities. The budget request for fiscal year 1976 would permit the conversion to conditional status of an additional 18 planning projects, for a total of 69 conditional PSRO's and 56 planning projects.

While there has not yet been an opportunity to evaluate current PSRO review activity, prototype organizations have documented a reduction in length of stay ranging from 0.3 to 2.2 days. Also, we estimate that concurrent review has resulted in a 1- to 3-percent reduction in admissions by eliminating unnecessary admissions. For example, the Utah PSRO has reported a 2-percent reduction.

An extensive monitoring system is now under development and should be ready for full implementation by late June 1975. The system will enable the Department to assess the performance of PSRO's on an individual and comparative basis to determine how well they are affecting charges in utilization patterns and the quality of care.

Mr. Conte. Can you tell me what success the National Health Service Corps has had in dealing with the problem of geographical maldistributions of health care personnel?

Dr. van Hoek. Between January 1, 1972 (when the first National Health Service Corps assignees were placed in communities) and July 1, 1974, a total of 559 assignees were recruited and placed in 235 different communities. During this 2½-year period, the 559 professionals recruited included 380 physicians, 93 dentists, and 86 physician extenders.

Of the 253 physicians placed through July 1, 1973, 54 have extended, at least for an additional year, and 38 have either established independent practices or are in their final extension year establishing a private practice capability in the sites. A total of 68 communities will have become independent as of June 30, 1975, either on the basis of National

Health Service Corps assignees remaining in the site and establishing a private practice, or from National Health Service Corps recruited physicians assuming a National Health Service Corps developed practice as an independent practice.

The HSA program plan calls for the capability of establishing an increasing number of independent and self-sufficient sites each year and utilizing NHSC resources to develop additional community practices. The plan anticipates that from 25 to 30 percent of staff sites will become independent and self-sufficient each year beginning in July of 1977.

The program presently is demonstrating its capability as a very cost-effective approach to the geographical maldistribution of professional manpower and cost projections over the next 3 to 4 years indicate that the average cost for each professional placed in the field should not exceed $35,000–$37,000 per professional for total program costs—including program management, recruitment, and site development. It is important to point out that the cash receipts collected for the services of National Health Service Corps professionals at site are first utilized to support the basic health care practice and that presently about an additional 800 health support staff are employed at National Health Service Corps sites without Federal funds being required.

In addition, it is anticipated that during fiscal year 1975 over $2 million will be returned to the U.S. Treasury as the reasonable costs of National Health Service Corps personnel assignment being collected from the communities' cash receipts collected in the health practices. It is anticipated that the amount to return to the Treasury in fiscal year 1976 will be in excess of $3½ million.

Maternal and Child Health

Mr. Conte. In maternal and child health, your justification again talks about third-party reimbursements and patient payments according to income. Aren't the people who really need and benefit from these programs those who cannot pay for them? And what makes you think that you will have greater success in getting third-party reimbursements now than in the past?

Dr. van Hoek. We will make every effort to continue to serve those most in need. There is no present information to assure that we will have increased third-party reimbursements since such efforts were not made in the past. The budget estimates are also based on increased cost sharing from State and local governments and private sources in order to continue existing service programs at their current operating level. Legislation has been proposed to mandate an increased level of cost sharing.

Mr. Conte. Thank you.

Mr. Flood. Thank you, gentlemen.

Dr. van Hoek. Thank you, Mr. Chairman.

Mr. CONTE. Why are you phasing out the section 314(d) program, which seems to be very popular with the State of Massachusetts? What do you foresee taking its place? Do you have any evidence that there are State funds available?

Dr. VAN HOEK. The 314(d) funds allocated to the State health department of Massachusetts constitute approximately 2.7 percent of reported State health department expenditures, excluding mental health services. Therefore, it is anticipated that the State health department will be able to make alternative arrangements for continued support of high priority programs supported by these funds.

Mr. CONTE. Thank you.

Mr. FLOOD. Thank you, Doctor.

Dr. VAN HOEK. Thank you, Mr. Flood.

Justification of the Budget Estimates

HEALTH SERVICES

For carrying out, except as otherwise provided, titles III, V, X[1/], XI, XII, and XIII of the Public Health Service Act, the Act of August 8, 1946 (5 U.S.C. 7901), section 1 of the Act of July 19, 1963 (42 U.S.C. 253a), section 108 of Public Law 93-353, and [title V] *titles V and XI*[2/] of the Social Security Act [$493,455,000] *$696,536,000*, of which $1,200,000 shall be available only for payments to the State of Hawaii for care and treatment of persons afflicted with leprosy: *Provided*, [That $3,000,000 shall remain available through June 30, 1976, pursuant to sections 1303(i) and 1304(k) of the Public Health Service Act: *Provided further*,][3/] That any amounts received by the Secretary in connection with loans and loan guarantees under title XIII and any other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets, shall be available to the Secretary without fiscal year limitation for direct loans and loan guarantees, as authorized by said title XIII, in addition to funds specifically appropriated for that purpose: *Provided further*, That [$1,600,000] *this appropriation*[4/] shall be available for payment of the costs of medical care, related expenses, and burial expenses, hereafter incurred, by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health, Education, and Welfare, and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease [fom] *from* syphilis contracted from such person [, to remain available until expended]:[4/] *Provided further*, That when the Health Services Administration operates an employee health program for any Federal department or agency, payment for the estimated cost shall be made by

way of reimbursement or in advance to this appropriation: *Provided further,* That in addition, [$5,774,000] *$24,671,000* may be transferred to this appropriation as authorized by [section 201(g)(1)] *sections 201(g)(1) and 1168*[5/] of the Social Security Act, from any one or all of the trust funds referred to therein [: *Provided further,* That $1,300,000 of the funds contained in this appropriation for construction and related activities shall remain available until expended].[6/]

[For carrying out, to the extent not otherwise provided, section 301(g) of the Public Health Service Act, $2,722,000.]

Explanation of Language Changes

1. Since the title X authorization had expired on June 30, 1974, this title was not cited in the 1975 Health Services appropriation; funds are being requested in 1976 under a proposed renewal of title X authority.

2. Since the budget for the Professional Standards Review Organizations (PSRO) program is included in this request, the authority for the PSRO program (title XI of the Social Security Act) is cited.

3. The special authorities contained in sections 1303(i) and 1304(k) expired on June 30, 1974.

4. The exact amount required for treating the Tuskegee study participants is difficult to estimate; therefore, the request to earmark a specific amount of funds for an indefinite period is being deleted and is being replaced with a general request for funds on an annual basis.

5. Section 1168 of the Social Security Act authorizes the transfer of trust funds for the support of the Professional Standards Review Organizations program.

6. No funds are requested for construction activities.

Language Provision	Explanation
Provided further, that this appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses, hereafter incurred, by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary, of Health, Education, and Welfare, and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease from syphilis contracted from such person.	There is no special legislative authority for this language; however, the Federal Government has a moral responsibility which this language seeks to fulfill.
Provided further, that when the Health Services Administration operates an employee health program for any Federal department or agency, payment for the estimated cost shall be made by way of reimbursement or in advance to this appropriation.	Provision of services to another Federal component, and payment to the providing Federal component by the receiving Federal component, are authorized by 31 U.S.C. 686; however, advances in payment for these services are authorized to be made only to a "special working fund" and not to an appropriation; the language modifies this restriction.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH SERVICES ADMINISTRATION

Health Services

Amounts Available for Obligation 1/

	1975 2/	1976
Appropriation	$493,455,000	$696,536,000
Enacted supplemental	2,722,000	---
Continuing resolution	423,820,000	---
Subtotal, adjusted appropriation	919,997,000	696,536,000
Comparative transfer to:		
"Indian Health": for the support of the California Rural Indian Health Board ($687,000); and for Indian related projects originally transferred from the Office of Economic Opportunity in 1974 ($3,065,000)	-3,752,000	---
"Departmental Management": for support of the establishment of an Office of Assistant Regional Director for Public Affairs in each region (5 positions and $135,000); for support of the Departmental Audio-visual Management Information System ($1,000); and for the support of the transfer of long term care personnel to the staffs of the Regional Directors (57 positions and $1,487,000 --- Trust Funds)	-1,623,000	---
"Office of the Assistant Secretary for Health": for the support of the Automated Terminal System ($19,000); and for the support of the centralized publications storage and distribution activity (3 positions and $39,000)	-58,000	---

1/ Excludes the following amounts for reimbursable activities carried out by other accounts: 1975 revised estimate $6,454,000; 1976 estimate $6,461,000.

2/ Excludes $11,403,000 for 1973 appropriation restorations.

Amounts Available for Obligation (continued) 1/

	1975 2/	1976
"Health Resources": for support of the publication "Public Health Reports", formerly published by the Health Services Administration under different title (2 positions)	-37,000	---
"Salaries and Expenses", Food and Drug Administration: for support of the Parklawn computer center, the management of which has been transferred to the Food and Drug Administration (7 positions)	-164,000	---
Comparative transfers from:		
"Health Resources": for support of the conversion of the Upward Mobility Program from a centralized activity managed by the Health Resources Administration to a decentralized activity managed by each agency (6 positions and $99,000); and for administrative support of the Emergency Medical Services program which has been transferred from the Health Resources Administration (25 positions and $984,000)	+1,083,000	---
"Office of the Assistant Secretary for Health": for support of the Professional Standards Review Organizations program which has been transferred from the Office of the Assistant Secretary for Health (155 positions)	+9,128,000	---
Receipts and reimbursements from:		
"Federal funds"	19,629,000	19,991,000
"Trust funds"	32,854,000	24,671,000
"Non-Federal sources"	1,274,000	1,274,000
Unobligated balance, start of year	74,475,000	4,181,000
Unobligated balance, transferred from Health Services and Mental Health Administration's buildings and facilities account	10,103,000	---
Unobligated balance, end of year	-4,181,000	-452,000
Total, obligations	$1,058,728,000	$746,201,000

1/ Excludes the following amounts for reimbursable activities carried out by other accounts: 1975 revised estimate $6,454,000; 1976 estimate $6,461,000.

2/ Excludes $11,403,000 for 1973 appropriation restorations.

Summary of Changes

1975 Estimated obligations	$1,058,728,000
1976 Estimated obligations	746,201,000
Net change	-312,527,000

	1975 Base Pos.	1975 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. 1975 Annualization of October 1974 pay raise	---	---	---	+2,635,000
2. Within grade and longevity increases	---	---	---	+2,372,000
3. One extra day of pay	---	---	---	+289,000
4. Increase in employee benefits	---	---	---	+93,000
5. Increase for DHEW Working Capital Fund	---	---	---	+334,000
6. Increase for HSA Service and Supply Fund	---	---	---	+172,000
7. Increase for Federal Telecommunications System	---	---	---	+87,000
8. Increase for Bureau of Employee Compensation	---	---	---	+82,000
9. Increased cost for penalty mail	---	---	---	+26,000
10. Increased rates for postage, utilities and miscellaneous rates	---	---	---	+519,000
11. Increases for contract medical care, services, supplies and equipment	---	---	---	+3,108,000
12. Annualization of PSRO new positions in 1975	---	---	---	+556,000
Subtotal	---	---	---	+10,273,000
B. Program:				
Quality Assurance				
(b) Professional Standards Review Organizations	155	$36,204,000	+18	+13,152,000
Total, increases	---	---	+18	+23,425,000

	1975 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Decreases:				
A. Built-in:				
PHS hospital repair and modernization projects nonrecurring	---	---	---	-$17,968,000
Subtotal	---	---	---	-17,968,000
B. Program:				
Community health services:				
(a) Community health centers.	---	$196,648,000	---	-41,458,000
(b) Comprehensive health grants to States	63	90,000,000	-63	-90,000,000
(c) Maternal and child health:				
(1) Grants to States	58	266,951,000	-58	-73,029,000
(2) Sudden infant death syndrome	10	2,000,000	-10	-2,000,000
(3) Research and training	---	25,917,000	---	-8,417,000
Subtotal	68	294,868,000	-68	-83,446,000
(d) Family planning	---	100,615,000	---	-21,180,000
(e) Migrant health	---	23,750,000	---	-4,550,000
(f) Health maintenance organizations:				
(1) Grants and contracts.	---	29,658,000	---	-14,658,000
(2) Program support	125	3,597,000	---	-63,000
(3) Loan and loan guarantee	---	35,000,000	---	-35,000,000
Subtotal	125	68,255,000	---	-49,721,000
(g) National health service corps	405	12,131,000	---	-78,000
Quality assurance:				
(a) Medical care standards	167	4,555,000	---	-164,000
Patient care and special health services:				
(a) Patient care	5,479	123,040,000	-678	-9,365,000
(b) Coast Guard medical services	151	8,760,000	---	-470,000
(c) Federal employee health	266	6,354,000	---	-21,000
Emergency medical service	---	37,000,000	---	-11,900,000
Program management	917	33,651,000	-10	-5,631,000
Subtotal	---	---	-819	-317,984,000
Total, decreases	---	---	-819	-335,952,000
Total, net change	---	---	-801	-312,527,000

Explanation of Changes

Increases:

A. Built-in:

1. 1975 annualization of October 1974 pay raise - The increase of $2,635,000 for the full year cost of the October 1974 pay raise includes: $15,000 for Health Maintenance Organizations, $198,000 for National Health Service Corps, $54,000 for Medical Care Standards, $102,000 for Professional Standards Review Organizations, $1,300,000 for Patient Care, $38,000 for Coast Guard Medical Services, $66,000 for Federal Employee Health, and $862,000 for Program Management.

2. Within grade and longevity increases - The increase of $2,372,000 for within grade and longevity includes: $6,000 for Health Maintenance Organizations, $161,000 for the National Health Service Corps, $82,000 for Medical Care Standards, $81,000 for Professional Standards Review Organizations, $1,641,000 for Patient Care, $12,000 for Coast Guard Medical Services, $55,000 for Federal Employee Health, and $334,000 for Program Management.

3. One extra day of pay - The increase of $289,000 for the one extra day of pay in 1976 includes: $8,000 for Health Maintenance Organizations, $41,000 for the National Health Service Corps, $10,000 for Medical Care Standards, $7,000 for Professional Standards Review Organizations, $160,000 for Patient Care, and $63,000 for Program Management.

4. Increase in employee benefits - The increase of $93,000 for increased payment of FICA benefits includes: $5,000 for Health Maintenance Organizations, $7,000 for the National Health Service Corps, $33,000 for Patient Care, $5,000 for Coast Guard Medical Services, and $43,000 for Program Management.

5. Increase for DHEW Working Capital Fund - The increase of $334,000 for the Working Capital Fund includes: $33,000 for Health Maintenance Organizations program support, $24,000 for Professional Standards Review Organizations, $100,000 for Patient Care, and $177,000 for Program Management.

- Increase for HSA Service and Supply Fund - The increase of $172,000 for the Service and Supply Fund includes: $69,000 for the National Health Service Corps, $10,000 for Professional Standards Review Organizations, and $93,000 for Patient Care.

- Increase for Federal Telecommunications System - The increase of $87,000 for F.T.S. includes: $11,000 for Health Maintenance Organizations program support, $9,000 for Professional Standards Review Organizations, $26,000 for Patient Care, and $41,000 for Program Management.

8. Increase for Bureau of Employee Compensation - The increase of $82,000 includes: $79,000 for Patient Care and $3,000 for Program Management.

9. Increased cost of penalty mail - The increase of $26,000 will support increased costs of penalty mail for Program Management.

10. Increased rates for postage, utilities, and miscellaneous items - The increase of $519,000 for increased postage rates, utility rates, and other rates will provide: $480,000 for Patient Care and $39,000 for Federal Employee Health.

11. Increase for contract medical care, services, supplies, and equipment - The increase of $3,108,000 will provide: $1,330,000 for Patient Care, $111,000 for Coast Guard Medical Services, and $200,000 for Federal Employee Health to support increases in contract medical care; $1,109,000 for Patient Care, $42,000 for Coast Guard Medical Services, and $9,000 for Federal Employee Health to support increased costs of supplies; $37,000 in Patient Care to support increases in other services; and $270,000 in Patient Care to support increased costs for equipment.

12. Annualization of PSRO new positions in 1975 - The increase of $556,000 will support the annualization cost of the 50 new positions for the Professional Standards Review Organizations' activity.

B. Program:

1. Quality Assurance:

(a) Professional Standards Review Organizations - The increase of $13,152,000 will provide $12,882,000 for conversion of 31 planning Professional Standards Review Organizations to conditional status, and $270,000 for 18 new positions.

Decreases:

A. Built-in:

PHS Hospital repair and modernization projects nonrecurring - The decrease of $17,968,000 results from the nonrecurring obligations to modernize and repair the PHS hospitals.

B. Program:

1. Community health services:

(a) Community health centers - The decrease of $41,458,000 will require increased non-Federal participation by State and local governments and by third-party payors such as Medicaid, Medicare, and private health insurers to maintain services at the 1975 level. Federal policy for the direct delivery of health care through grant programs emphasizes increased cost sharing by States, local governments, and third-party payors.

(b) Comprehensive health grants to States - Elimination of this grant activity totaling $90,000,000 is recommended as part of the overall effort to reduce Federal outlays.

(c) Maternal and child health - The decrease of $83,446,000 is based on the passage of legislation that will increase grantee matching rates to maintain the 1975 program level. Emphasis will be placed on collecting third-party reimbursements and patient payments according to income.

(d) Family planning - The decrease of $21,180,000 will require increased non-Federal participation by State and local governments and by third-party payors such as Medicaid, Medicare, and private health insurers to maintain services at the 1975 level. Federal policy for the direct delivery of health care through grant programs emphasizes increased cost sharing by States, local governments, and third-party payors.

(e) Migrant health - The decrease of $4,550,000 assumes increased funding from non-Federal sources and higher levels of third-party reimbursements to maintain services at the 1975 level.

(f) Health maintenance organizations - The total reduction of $49,721,000 includes decreases of: $35,000,000 for nonrecurring capitalization of the loans and loan guarantee fund, $14,658,000 for grants, and $63,000 for reduction of technical assistance contracts. Funding under the HMO Act was not appropriated until very late in 1974 and grants were not awarded until 1975. Given this late start, the 1976 program will emphasize the certification of existing HMOs and fostering their penetration into the market under the dual option provision.

(g) National health service corps - The decrease of $78,000 results from the mandatory increase in the Service and Supply Fund. The decrease is related to recruitment activities designed to attract health professionals to serve as Corps staff in major critical health scarcity areas.

2. Quality assurance

(a) Medical care standards - A decrease of $164,000 in program operations will provide for absorption of within grade and longevity increases, bonus pay costs and the one extra day of pay. This will be accomplished by delaying the filling of vacancies for a savings of $92,000 and four manyears, and reducing other related expenses for a savings of $72,000.

3. Patient care and special health services

(a) Patient care - The decrease of $9,365,000 reflects the following: a reduction resulting from the one time expenditure of the 1975 congressional increase of $3,500,000 for 393 positions which will be terminated in July 1975, program cutback including a reduction of 250 non-patient care positions and $4,865,000; and a program cutback including 35 positions and $1,000,000 in hospital research activities.

(b) Coast Guard medical services - The decrease of $470,000 reflects the termination of the alcoholism rehabilitation program for $430,000, and the reduction of consultant services amounting to $40,000.

(c) Federal employee health - The decrease of $21,000 results from the mandatory increases and will be absorbed by reducing the average paid employment by one manyear.

4. Emergency medical services - The decrease of $11,900,000 reflects a reduction of approximately 58 grants and contracts to be awarded in 1976.

5. Program Management - The total decrease of $5,631,000 reflects a decrease of $3,266,000 which includes $2,222,000 for technical assistance to health service delivery projects, $750,000 for maternal and child health services for the Indian people, and $294,000 for services to the national health service corps and related projects; $2,315,000 including a 90 manyear reduction; and $50,000 for a reduction of 10 budgeted positions related to the national health service corps program.

Obligations by Activity*

Page Ref.		1975 Estimate 1/ Pos.	1975 Estimate 1/ Amount	1976 Estimate Pos.	1976 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
26	Community health services:						
30	(a) Community health centers.....	---	$196,648,000	---	$155,190,000	---	-$41,458,000
32	(b) Comprehensive health grants to States.....	63	90,000,000	---	---	-63	-90,000,000
33	(c) Maternal and child health:						
34	(1) Grants to States.....	58	266,951,000	---	193,922,000	-58	-73,029,000
37	(2) SIDS.....	10	2,000,000	---	---	-10	-2,000,000
38	(3) Research and training.....	---	25,917,000	---	17,500,000	---	-8,417,000
	Subtotal...	68	294,868,000	---	211,422,000	-68	-83,446,000
40	(d) Family planning..	---	100,615,000	---	79,435,000	---	-21,180,000
44	(e) Migrant health...	---	23,750,000	---	19,200,000	---	-4,550,000
46	(f) Health maintenance organizations:						
47	(1) Grants and contracts....	---	29,658,000 (4,658,000)	---	15,000,000 (15,000,000)	---	-14,658,000 (+10,342,000)
48	(2) Program support.....	125	3,597,000	125	3,612,000	---	+15,000
48	(3) Loan & loan guarantee....	---	35,000,000 (---)	---	--- (---)	---	-35,000,000 (---)
	Subtotal Obligations.	125	68,255,000 (8,255,000)	125	18,612,000 (18,612,000)	---	-49,643,000 (+10,357,000)
50	(g) National health service corps...	405	12,131,000	405	12,529,000	---	+398,000
	Subtotal, Obligations.	661	786,267,000 (726,267,000)	530	496,388,000 (496,388,000)	-131	-289,879,000 (-229,879,000)
52	Quality assurance:						
53	(a) Medical care standards.....	167	4,555,000 (268,000)	167	4,537,000 (---)	---	-18,000 (-268,000)
56	(b) Professional standards review organizations...	155	36,204,000 (9,124,000)	173	50,145,000 (30,011,000)	+18	+13,941,000 (+20,887,000)
	Subtotal, obligations.	322	40,759,000 (9,392,000)	340	54,682,000 (30,011,000)	+18	+13,923,000 (+20,619,000)

*Where budget authority differs from obligations, budget authority is shown in parentheses.

1/ Excludes $11,403,000 for 1973 appropriation restorations.

Obligations by Activity*

Page Ref.		1975 Estimate Pos.	1975 Estimate Amount	1976 Estimate Pos.	1976 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
60	Patient care and special health services:						
61	(a) Patient care	5,479	$123,040,000	4,801	$120,333,000	-678	-$2,707,000
			(107,871,000)		(105,164,000)		(-2,707,000)
63	(b) Coast Guard medical services	151	8,760,000	151	8,498,000	---	-262,000
64	(c) Federal employee health	266	6,354,000	266	6,702,000	---	+348,000
			(620,000)		(606,000)		(-14,000)
65	(d) Payment to Hawaii	---	1,200,000	---	1,200,000		---
	Subtotal, obligations	5,896	139,354,000	5,218	136,733,000	-678	-2,621,000
			(118,451,000)		(115,468,000)		(-2,983,000)
66	Buildings and facilities	---	21,697,000	---	3,729,000	---	-17,968,000
			(1,300,000)		(---)		(-1,300,000)
67	Emergency medical services	---	37,000,000	---	25,100,000	---	-11,900,000
70	Program management	917	33,651,000	907	29,569,000	-10	-4,082,000
	Total obligations		1,058,728,000		746,201,000		-312,527,000
		7,796	(926,061,000)	6,995	(696,536,000)	-801	(-229,525,000)

* Where budget authority differs from obligations, budget authority is shown in parentheses.

1/ Excludes $11,403,000 for 1973 appropriation restorations.

Obligations by Object

	1975 Estimate	1976 Estimate	Increase or Decrease
Total number of permanent positions	7,796	6,995	-801
Full-time equivalent of all other positions	425	425	---
Average number of all employees	7,676	7,232	-444
Personnel compensation:			
Permanent positions	$100,240,000	$97,467,000	$2,773,000
Positions other than permanent	5,272,000	4,896,000	-376,000
Other personnel compensation	6,867,000	6,542,000	-325,000
Special personal services payments	375,000	375,000	---
Subtotal, personnel compensation	112,754,000	109,280,000	-3,474,000
Personnel benefits	22,085,000	21,944,000	-141,000
Benefits for former personnel	100,000	400,000	+300,000
Travel and transportation of persons	4,042,000	4,031,000	-11,000
Transportation of things	1,343,000	1,354,000	+11,000
Rent, communications and utilities	8,663,000	8,144,000	-519,000
Printing and reproduction	682,000	575,000	-107,000
Other services	40,451,000	29,957,000	-10,494,000
Project contracts	47,397,000	52,182,000	+4,785,000
Supplies & materials	14,150,000	13,803,000	-347,000
Equipment	3,182,000	2,567,000	-615,000
Lands and structures	8,250,000	1,417,000	-6,833,000

51-805 O - 75 -- 14

Obligations by Object

	1975 Estimate	1976 Estimate	Increase or Decrease
Investments and loans.....	35,000,000	---	-35,000,000
Grants, subsidies and contributions.....	760,829,000	500,747,000	-260,082,000
Subtotal.....	1,058,928,000	746,401,000	-312,527,000
Deduct quarters and subsistance charges (-).....	-200,000	-200,000	---
Total obligations by object.....	1,058,728,000	746,201,000	-312,527,000

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action Taken or to be Taken
1975 House Report	
Maternal and Child Health	
1. The Committee added $18,000,000 for the MCH program in order for all States to receive no less funds in 1975 than they received in 1973 as required by Title V and to provide expanded health services to mothers and children.	Congressional action resulted in an appropriation of $23,000,000 above the President's budget request of $243,951,000 for Maternal and child health formula grants to States. Of the $23,000,000 appropriated for formula grants to States, $20,100,000 will be used to assure that all States will receive no less funds in 1975 than they received in 1973. These funds were made available to the States on March 18, 1975.
2. The Committee also directed that a cadre of MCH staff be maintained within the Department in order to assist the States in meeting their statutory obligation to mount a program of projects which will include maternal and infant care, children and youth, dental, newborn intensive care and family planning projects.	The end-of-year employment ceiling for the Bureau of Community Health Services will be increased in 1975 to allow for the immediate hiring of 58 positions. These positions will be used exclusively for Title V Maternal and child health activities. Of the additional $23,000,000 appropriated for formula grants to States, $900,000 will be made available to support these positions.
3. The Committee recommended $1,000,000 for Sudden Infant Death Syndrome, also known as crib death, for the purpose of introducing an awareness of this problem among health care providers and to develop more effective ways of assisting families following such a loss.	$2,000,000 was appropriated in 1975 for the purposes described. The end-of-year employment ceiling for the Bureau of Community Health Services will be increased by 10 positions to support this activity. Approximately $150,000 in support costs are designated for activities related to Sudden infant death syndrome and will also be utilized by the Maternal and child health program.
4. The Committee added $10,000,000 for the Emergency Medical Services program to further develop self-supporting area-wide Emergency Medical Service systems.	An additional 49 grants and contracts will be awarded in 1975 to expand the program of providing emergency medical services to the civilian population.

Significant Items in House and Senate Appropriations Committee Reports

Item	Action Taken or to be Taken
1975 Senate Report	
1. The Committee recommended an increase of $20,000,000 over the House allowance for the MCH program in order for all States to receive no less funds in 1975 than they received in 1973 as required by Title V and to provide expanded health services to mothers and children.	Congressional action resulted in an appropriation of $23,000,000 above the President's budget request of $243,951,000 for Maternal and child health formula grants to States.
2. The Committee recommended support of pediatric pulmonary centers across the country.	$2,000,000 of the $23,000,000 appropriated above the President's budget request for MCH grants to States will be used for the support of pediatric pulmonary centers in 1975.
3. The Committee noted that there was a continuing need to provide technical assistance to States in the establishment of programs of projects. For this purpose they included 58 positions and $900,000.	The end-of-year employment ceiling for the Bureau of Community Health Services will be increased in 1975 to allow the immediate hiring of 58 positions. These positions will be used exclusively for Title V Maternal and child health activities. Of the additional $23,000,000 appropriated for formula grants to States, $900,000 will be made available to support these positions.
4. The committee recommended an increase of $1,000,000 over the House allowance for the SIDS program. Of the $2,000,000 provided by the Senate Committee $150,000 will support 10 positions, while $1,850,000 will provide for the preparation and dissemination of information and materials.	$2,000,000 was appropriated in 1975 for the purposes described. The end-of-year employment ceiling for the Bureau of Community Health Services will be increased by 10 positions to support this activity. Approximately $150,000 in support costs are designated for activities related to sudden infant death syndrome and will also be utilized by the Maternal and child health program.
5. The Committee added $4,000,000 for MCH research and training activities to train personnel and establish the medical care delivery capacity with medical funds, as well as strengthening existing University-affiliated facilities	Of the $4,000,000 appropriated, $350,000 will provide a new University-affiliated training center, $1,650,000 for strengthening existing University-affiliated centers and training physician assistants and nurse practitioners, $2,000,000 for 25 research studies.

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action Taken or to be Taken
6. The Senate added $3,500,000 to support the restoration of 393 positions for the patient care and specific health services program to assume compliance with Section 818 of P.L. 93-155.	During 1975, the Public Health Service hospitals and clinics will utilize the added positions and funds to rebuild employment in the hospital system and to strengthen other areas of the patient care program, such as the purchase of drugs and medical supplies. With these added resources, the hospital system will improve its patient care capabilities for beneficiaries and expand community-related programs such as alcoholism, drug abuse, mental health, and Sickle cell and Cooley's anemia screening, counseling, and treatment.

Authorizing Legislation

Legislation	1976 Authorized	1976 Appropriation requested
Public Health Service Act:		
Title III		
Section 310 -- Migrant Health Grants	1/	$19,200,000
Section 314(e) -- Project Grants for Health Services Development	1/	155,190,000
Section 329 -- Assignment of Medical and Other Health Personnel to Critical Need Areas	1/	12,529,000
Section 331 -- Lepers	Indefinite	1,200,000
Title X		
Section 1001 -- Family Planning Service Projects.	1/	75,135,000
Section 1003 -- Family Planning Training Projects.	1/	2,000,000
Section 1004 -- Family Planning Research	1/	2,000,000
Section 1005 -- Family Planning Information and Education	1/	300,000
Title XII		
Section 1207(a) -- Emergency Medical Service Grants and Contracts	$ 70,000,000	22,600,000
Section 1207(b) -- Emergency Medical Service Research	5,000,000	2,500,000
Title XIII		
Section 1309(a) -- Health Maintenance Organizations grants and contracts for feasibility surveys, planning, and initial development	85,000,000	15,000,000
Social Security Act:		
Title V		
Section 501 -- Maternal and Child Health and Crippled Children's Services	350,000,000	211,422,000
Title XI		
Section 1168 -- General Provision and Professional Standards Review	Indefinite	30,011,000

1/ Authorization expired June 30, 1974

Health Services

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1966	$196,616,000	$197,480,000	$183,480,000	$197,980,000
1967	242,521,000	242,271,000	242,271,000	242,271,000
1968	410,599,000	383,406,000	384,209,000	383,806,000
1969	513,476,000	454,847,000	457,847,000	456,347,000
1970	453,507,000	461,297,000	463,207,000	463,207,000
Trust funds transfers	4,320,000	4,320,000	4,320,000	4,320,000
1971	519,798,000	519,798,000	525,940,000	521,248,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1972	652,219,000	656,237,000	697,118,000	667,687,000
Trust fund transfers	3,112,000	3,112,000	3,112,000	3,112,000
1973	698,382,000	743,622,000	837,124,000	743,622,000
Trust fund transfers	7,587,000	7,587,000	7,587,000	7,587,000
1974	820,923,000	820,923,000	864,273,000	927,091,000
Trust fund transfers	20,901,000	20,901,000	20,901,000	20,901,000
1975 considered	485,096,000	492,975,000	519,570,000	503,570,000
Continuing resolution	423,820,000			
Trust fund transfers	34,341,000	34,341,000	34,341,000	34,341,000
1976	696,536,000			
Trust fund transfers	24,671,000			

Justification

Health Services

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	7,796	$134,939,000	6,995	$131,624,000	-801	-$3,315,000
Other expenses	---	923,789,000	---	614,577,000	---	-309,212,000
Total	7,796	1,058,728,000	6,995	746,201,000	-801	-312,527,000

General Statement

The primary objectives of the Health Services Administration are to provide health services for the underserved or disadvantaged, to build health services delivery capacity in medically underserved areas, to assure the quality of health care, to foster effective and efficient health services delivery, and to provide services to statutorily defined populations. In fiscal year 1976 the Health Services Administration will work toward the achievement of these goals by emphasizing efforts to increase third-party reimbursements in its services delivery programs. In this fiscal year State and local participation in both the cost-sharing and the management of these programs will be increased, because State and local governments are in a better position than the Federal Government to determine their own needs and priorities in the delivery of health services and to accept a greater share of the responsibility for the provision of these services.

The Health Services Administration will also emphasize increased productivity in existing programs which have been shown to provide health services in the most cost-effective manner. Efforts will be made to better coordinate and integrate existing categorical program resources at the grantee level, and third-party, State and local health resources in order to avoid duplication and assure cost effectiveness.

The programs administered by the Bureau of Community Health Services have fundamental interests in the extension of service capacity in order to resolve problems of access to health care. They provide a mechanism for meeting the special health needs of people in various regions, and for meeting those needs considered to be of national significance. Efforts are underway to increase third-party reimbursements in the Community Health Centers, Migrant Health Centers, the Maternal and Child Health formula grant program, and the Family Planning program. In addition, the application of program indicators and reporting requirements in project grant programs have produced and will continue to produce improved project management and decreases in the annualized total costs per person served. Finally, BCHS will give priority to improving the organization and financing of delivery systems (HMO) and the redistribution of health manpower to medically underserved areas (National Health Service Corps).

1/ Excludes $11,403,000 for 1973 appropriation restorations.

The national concerns about the quality of health care are priorities which are demonstrated by HSA's responsibilities for implementing the Professional Standards Review Organization (PSRO) program, the End Stage Renal Disease program, and other quality assurance activities. PSROs provide a mechanism for professional control over the inappropriate utilization of health services and monitoring of medical practice. This should lead to improvements in the quality of care rendered to all consumers.

The Bureau of Medical Services will continue to provide health care to American seamen, personnel and dependents of the Coast Guard and the Public Health Service Commissioned Corps, and other statutory recipients. The Bureau will also continue to implement the Emergency Medical Services program to develop and expand systems which coordinate the delivery of health care services under all emergency conditions.

In summary, HSA programs are designed to assure the Nation's citizens equity in obtaining quality health care, appropriate to their needs.

Community Health Services

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	661	$14,409,000	530	$13,155,000	-131	-$1,254,000
Other expenses	---	771,858,000	---	483,233,000	---	-288,625,000
Total	661	786,267,000	530	496,388,000	-131	-289,879,000

Introduction

The Bureau of Community Health Services programs have fundamental interests in the extension of service capacity in order to resolve problems of access to health care. They provide a mechanism for meeting special health needs of people in various regions, for meeting those needs considered to be of national significance and for developing and initially supporting new health services programs. Through a variety of health service funding or support mechanisms the programs foster a comprehensive approach to health care services with special emphasis on reaching underserved segments of the population. As an integral part of the Health Services Administration, the Bureau's activities are coordinated with programs serving statutorily defined populations, the Indian Health Service and Federal Health Programs Service. Its efforts in maintaining service effectiveness are related to the programs of the Bureau of Quality Assurance.

Community health center project grants help low-income persons through the provision of health care in neighborhood and family health centers. Maternal and child health formula grants assist States in providing health services to low-income mothers and children and to crippled children. Services provided through the formula grant program are augmented through the maternal and child health research and training programs. Family planning project grants and contracts give low-income people the opportunity to determine the number and spacing of their children. Access to health care services is provided to migrant and seasonal farmworkers and their families through health service project grants located in migrant work areas. The Health Maintenance Organization program provides a stimulus for the development of local organizations which provide health services for a fixed prepaid fee. They emphasize disease prevention and the early and ambulatory treatment of illness. The National Health Service Corps provides direct health care through the placement of health personnel in areas where health manpower is scarce or non-existent.

1/ Excludes $11,403,000 for 1973 appropriation restorations.

The proposed budget for the community health services program emphasizes increased cost-sharing by States, local governments, and other agencies and increased third-party reimbursements. The 1976 budget assumes an estimated increase of approximately 20 percent in non-Federal funding and third-party reimbursements. These funds will be used to offset the Federal reductions of approximately 20 percent in the community health centers, migrant health centers, family planning program, maternal and child health formula grants and the phase out of the 314(d) grant program.

Grantees will be assisted in recovering third-party reimbursements for services that are covered by State Medicaid plans, the Medicare program or private health insurance. To facilitate this effort, the Department will propose an amendment to the Social Security Act requiring non-hospital affiliated health clinics to be included on each State Medicaid plan.

Community Health Services

	1975 1/ Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
1. Community health services:						
(a) Community health centers.....	---	$196,648,000	---	$155,190,000	---	-$41,458,000
(b) Comprehensive health grants to States.....	63	90,000,000	---	---	-63	-90,000,000
(c) Maternal and child health:						
(1) Grants to States.....	58	266,951,000	---	193,922,000	-58	-73,029,000
(2) Sudden Infant Death Syndrome...	10	2,000,000	---	---	-10	-2,000,000
(3) Research and Training...	---	25,917,000	---	17,500,000	---	-8,417,000
(d) Family planning.....	---	100,615,000	---	79,435,000	---	-21,180,000
(e) Migrant health.....	---	23,750,000	---	19,200,000	---	-4,550,000
(f) Health maintenance organizations.. 2/	125	68,255,000	125	18,612,000	---	-49,643,000
(g) National health service corps..	405	12,131,000	405	12,529,000	---	+398,000
Total.....	661	786,267,000	530	496,388,000	-131	-289,879,000

1/ Excludes 1973 appropriation restorations.

2/ Includes $35,000,000 for the capitalization of the loan and loan guarantee fund. These funds were provided in the 1974 supplemental appropriation and are nonrecurring in 1976.

Recipients of Community Health Services
(Number of Persons Served)

	1975 Estimate	1976 Estimate
I. Community health centers		
A. Neighborhood health centers.....	1,390,000	1,390,000
B. Family health centers.....	35,000	35,000
II. Maternal and child health services		
A. Grants to States:		
1. Maternal and child health services		
(a) Prenatal and postpartum care.....	600,000	600,000
(b) Family planning services.	1,968,000	1,968,000
(c) Well-child conferences...	1,805,000	1,805,000
(d) Nursing services.....	3,063,000	3,063,000
(e) Hospital admissions for comprehensive services.	166,000	166,000
(f) Children receiving dental health services.....	984,000	984,000
2. Crippled children's services:		
(a) Physicians' services.....	550,000	550,000
(b) Hospital inpatient care..	80,000	80,000
III. Family planning services.....	1,600,000	1,600,000
IV. Migrant health services.....	390,000	390,000
V. National health service corps.....	600,000	600,000

Community Health Centers

	1975 Estimate[1/]		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other Expenses.....	---	$196,648,000	---	$155,190,000	---	-$41,458,000

Introduction

The major focus of the Community Health Centers' program continues to be the support of ambulatory health care projects which provide primary health care and arrange for specialty and inpatient care, particularly in areas where health resources are scarce or non-existent. The flexibility of the Community Health Center program has been used to encourage the development of different models of health care delivery which are responsive to the needs of specific population groups.

Neighborhood health centers are ambulatory health care programs located in rural and urban health underserved areas. They integrate a broad range of health and social services into a single organization. These projects assure accessible ambulatory care and incorporate sound preventive health measures. They are predicated on total family care and are designed to insure continuity of high quality health care. Family health centers are prepaid health care programs that emphasize primary and ambulatory care in urban and rural underserved areas. On a prepaid capitation basis, they deliver or arrange for the delivery of health maintenance and treatment services to enrolled populations.

In 1976, efforts to improve management efficiency, program effectiveness and the quality of care will be made so as to maintain high quality health care for those who live primarily in medically underserved areas.

The proposed budget of $155,190,000 together with increased non-Federal support will provide for continued services to the 1,425,000 persons currently served by community health centers. It is expected that non-Federal sources will contribute additional funds necessary to maintain project operations and the 1975 level of services. These sources included State and local governments as well as private voluntary organizations.

The 157 operational community health centers which include family health centers, provided a range of preventive, curative, and rehabilitative ambulatory services and arranged for inpatient services to an estimated 1,425,000 persons in 1975. Significant program activity has been devoted to working with health

1/ Excludes $313,000 for 1973 appropriation restorations.

centers to enable them to improve their overall management capabilities. Priority has been placed on strengthening financial management to increase third-party reimbursement levels from 17 percent of total operational costs in 1974 to 20 percent in 1975.

The introduction of ambulatory health care standards and the development of project specific action plans responsive to external quality of care audits have enabled the centers to develop and maintain a high level of service quality for an expanded patient load. An October, 1973 study of the hospital utilization experience of persons using five neighborhood health centers showed a marked decrease in inpatient hospitalization as compared with the national experience. For the five centers participating in the study, the average hospital utilization was 762 hospital days per 1,000 patients per year compared with a national average of 1,160 hospital days per 1,000 patients. The hospitalization usage in those five centers is at a rate significantly lower than experienced with provider plans (1,109 days) or indemnity plans (864 days) and approaches group practice experience (526 days).

Explicit program expectations were developed using already defined program reporting requirements. These program indicators were introduced and permitted improved project funding decisions in 1975. Improvements in project management by judicious application of the Program Indicators and Funding Criteria resulted in an overall decrease of 14 percent in the annualized total cost per person served by the Centers (from $238 in 1974 to $206 in 1975.) Data reported in the 1974 Statistical Abstract of the United States for the total population indicate that the national per capita cost for services which are most comparable to those delivered in Community Health Centers is $214.

Comprehensive Health Grants to States

	1975 Estimate[1]		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...	63	$1,385,000	---	---	-63	-$1,385,000
Other expenses.....	---	88,615,000	---	---	---	-88,615,000
Total.....	63	90,000,000	---	---	-63	-90,000,000

Introduction

Formula grants awarded to State public health and mental health authorities under Section 314(d) of the Public Health Service Act assist the States in establishing and maintaining adequate public health services in accord with priorities and goals established by the States.

Because 314(d) funds allocated to State health authorities in the aggregate constitute only approximately four percent of the reported expenditures of State health departments and because it is anticipated that States will be able to make alternative arrangements for continued support of high priority programs supported with these funds, the Department is requesting no funds in 1976.

The States have used these funds to support communicable disease control programs such as venereal disease and tuberculosis activities; chronic disease programs directed toward such major causes of death and disability as heart disease, cancer, diabetes and stroke; and environmental health services, including food and drug protection, industrial health, radiological health, sanitary engineering and air and water pollution. In addition, laboratory services, home health and public health nursing services, and community mental health services, including treatment of alcoholism, drug abuse, and suicide prevention have been included. These kinds of activities are also supported by other programs in the Department.

1/ This is the continuing resolution level. A revised level of $67,500,000 may be requested based on a rescission proposal which may be submitted to the Congress.

	1975 1/ Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	68	$680,000	---	---	-68	-$680,000
Other expenses.....	---	294,188,000	---	$211,422,000	---	-82,766,000
Total.....	68	294,868,000	---	211,422,000	-68	-83,446,000
Subactivities:						
(1) Grants to States (Sections 503, 504 and 516).....	58	266,951,000	---	193,922,000	-58	-73,029,000
(2) Sudden Infant Death Syndrome information dissemination (Title XI)...	10	2,000,000	---	---	-10	-2,000,000
(3) Research (Section 512 and training Section 511).....	---	25,917,000	---	17,500,000	---	-8,417,000
Total.....	68	294,868,000	---	211,422,000	-68	-83,446,000

1/ Excludes $10,472,000 for 1973 appropriation restoration.

Introduction

The Title V maternal and child health and crippled children programs enable each State to extend and improve services for promoting the health of mothers and children. In addition to providing services, standards of care are developed, clinical research findings are implemented, and health professionals are trained. The program is also designed to develop and improve services for locating and diagnosing children who suffer from crippling diseases or potentially crippling conditions and providing them with medical care. These purposes and goals are achieved through a State formula grant program for maternal and child health and for crippled children services and through project grants for research and training. Under Title XI of the PHS Act, an information dissemination program is administered relating to sudden infant death syndrome.

Grants to States: In 1976, delivery of maternal and child health and crippled children services will continue at the 1975 program levels. This assumes that in 1976 there will be increased State, local, and third party financing to offset the reduction in Federal funds. Emphasis will be placed on improving financial management and other technical assistance to State health agencies which might assist them in supporting services to mothers and children and prepare them for becoming providers of services under insurance and public health care financing programs.

During 1976 the mental retardation projects and the reserve fund B special projects of regional and national significance will undergo review and assessment to determine effectiveness and consistency with long-range objectives of the Maternal and Child Health program. Services which are supported by mental retardation and reserve fund B resources are expected to remain at current levels as a result of increased State and local support.

The 1976 budget does not specifically include $2,000,000 required to continue the pediatric pulmonary program at the 1975 appropriated level. The ten pediatric pulmonary centers are located in hospitals or university medical centers, and it is hoped that these institutions will be able to secure sufficient non-Federal support in order to continue the most essential treatment programs and training activities.

The provisions of P.L. 93-53 were implemented in 1975. Section 516 of the law requires that for any fiscal year no State shall receive less funds under the Section 503 maternal and child health and Section 504 crippled children formula grant programs than its 1973 formula plus project grant allocation.

The project grant activities authorized by Sections 508, 509, and 510 were incorporated into a program of projects requirement for each State in 1975. In addition, each State must have a program in each of the five project categories listed below:

	Jurisdictions		
	Meeting Requirement	Required by P.L. 93-53	To be Implemented in 1975
Maternity and Infant Care	36	56	20
Children and Youth: Comprehensive	31	56	25
Children and Youth: Dental	15	56	41
Intensive Infant Care	8	56	48
Family Planning	27	56	29

New projects mandated for start-up in 1975 totalled 163. Due to the increased funding level in 1975 sufficient resources were made available to States to enable them to meet the programs of projects requirements.

The following is a description of the five project categories:

(1) Maternity and Infant Care Projects: These projects serve areas experiencing high infant and maternal mortality rates and in medically underserved areas. Patients provided services under these projects had a lower incidence of prematurity and conditions leading to mental retardation and other handicapping conditions caused by complications related to child bearing.

In 1965 the Denver, Colorado maternity and infant care project was started, and 18.9 percent of the babies delivered weighed less than 5 1/2 pounds. In 1972 only 12.8 percent were in the low birth weight range. The Birmingham, Alabama project reduced its fetal death rate from 21.7 per 1,000 births in 1966, when the project started, to 12.9 in 1971. During these same years the project's neonatal death rate fell from 25.4 to 18.1. In the Baltimore, Maryland, maternity and infant care project the 1964 infant mortality rate of 30.0 per 1,000 live births fell to 20.4 in 1972. When this Baltimore maternity and infant care project started in 1964 there were 12 maternal deaths; in 1974 there were none, a totally unprecedented event for Baltimore. In Dade County, Florida the maternal mortality rate in 1972 was 2.2 per 10,000 live births while the maternity and infant care project in that county had no maternal deaths. At Grady Memorial Hospital in Atlanta, Georgia, there were six maternal deaths in 1964, the year preceding the start of maternity and infant care project services, representing a maternal mortality rate of 8.8 per 10,000 live births. In 1972 there were three maternal deaths, a rate of 5.4 per 10,000 live births.

In Houston, Texas, there were five maternal deaths among maternity and infant care patients delivering at Jefferson Davis Hospital in 1964 and only one in 1972, even though the numbers of live births increased from 6,662 in 1964 to 9,997 in 1972.

(II) Comprehensive Care for Children and Youth Projects: Children enrolled in these projects receive continuous health supervision including a range of assessment examinations, follow-up treatment, aftercare, and preventive care. Immunizations and screening programs for high-risk school children are also important activities of these projects. Since the inception of this program the annual cost of care per registrant has decreased from $201 to $130; hospitalization rates for the populations served have declined from 8 percent to 2.4 percent, and the length of hospital stay per registrant has decreased from 10 days to 6.7 days.

(III) Dental Health for Children Projects: These projects provide dental treatment and education in dental hygiene to children and youth in low income areas. In addition dental demonstrations focus on developing new methods of diagnosis and treatment and innovative uses of dental personnel with various levels of training.

(IV) Intensive Infant Care Projects: These projects are demonstrating that by using sophisticated methods of care the number of infants who survive high-risk births can be increased. At Temple University, since the inception of the neonatal intensive care program, there has been a decrease of about one-third in the hospital's infant mortality rate. For the 1973 calendar year Temple's infant mortality rate was 21.2 per 1,000 live births.

At the Robert B. Green Nursery in San Antonio, Texas, the neonatal death rate was 24.5 per 1,000 live births in the spring of 1970, before the nursery was established. In 1973, with an increase of more than 800 live births, the death rate has been reduced to 12.3. The percentage of infants weighing less than 5 1/2 pounds went down from 12.5 percent in 1969 to 9.4 percent in 1973.

Extremely complex monitoring equipment and highly trained medical and nursing specialists are essential to this kind of care. Efforts have been made to staff these projects with such personnel.

(V) Family Planning: Referrals and services from these projects include physical examinations, laboratory tests, contraceptive supplies, education and social services. Participation in this program is strictly voluntary on the part of the client.

Crippled Children Services: State crippled children's programs are recognizing a wider range of handicapping conditions, and they are attempting to implement programs to meet the needs. Some States have recently modified their diagnostic eligibility requirements to include such conditions as hemophilia (Florida and Virginia), sickle cell anemia (Texas), and cystic fibrosis (New Mexico). Early and periodic screening, diagnostic and treatment in Iowa has increased the crippled children caseload by 10 percent. The estimated number of crippled children served in FY 1975 is 550,000.

Almost all 56 jurisdictions are operating clinical services for mentally retarded children. Services include diagnosis, evaluation of a child's developmental pattern, the development of a treatment and management plan, interpretation of findings and counseling of parents, and follow-up care. Children are being seen at special clinics at an earlier age as a result of multiple screening procedures carried out by the State maternal and child health programs. The mental retardation program identifies children thought to be retarded, removes the label of "mentally retarded" from children who suffer other developmental abnormalities, and provides preventive programs to children in the locality where they live.

It is estimated that over 70,000 children were served in this program in 1975.

During 1975 the maternal and child health program provided partial support to 10 pediatric pulmonary centers. The largest category of chronic illness in children under age 17 is chronic pulmonary disease, affecting 10,809,000 children with diseases such as cystic fibrosis and asthma. These centers provided services to over 30,000 of these children.

The estimated numbers of mothers and children served during 1975 under all Title V programs are listed below:

NUMBER OF PEOPLE SERVED*
(in thousands)

	1975
Mothers receiving prenatal and postpartum care	600
Women receiving family planning services and referrals	1,968
Children attending well-child conferences	1,805
Crippled children receiving physician services	550
Children registered for comprehensive services	568
Children receiving dental treatment	984
Infants admitted to comprehensive services	166
Pediatric Pulmonary Centers	31
Children Receiving Nursing Services	3,063
Children Screened:	
Visual screening	9,846
Audiometer testing	6,564
Dental screening	3,282
Immunizations (include booster and revaccinations):	
Polio	3,008
Rubella	3,282
Diphtheria	3,282

* Non-add

Sudden Infant Death Syndrome: The 1976 budget does not specifically include funds for either staff or grant support to continue the sudden infant death syndrome program at the 1975 appropriated level. The activities initiated with 1975 resources at the Federal level have provided impetus for States and communities to initiate service[illegible]h their own resources.

Direct consultation was provided to communities concerned about community-wide management of sudden infant death syndrome and its impact on families. The staff participated on the sudden infant death syndrome Interdepartmental Committee and awarded 30 grants to implement service and information programs. The goals of the service programs are 1) to provide counseling services for families which lose a child due to sudden infant death syndrome, 2) to increase the awareness of the public in general and community emergency service personnel in particular, and 3) to develop and strengthen linkages between community agencies such as health agencies, mental health agencies, and coroner or medical examiner's offices, police and fire departments. Approximately 90 percent of the $2,000,000 appropriation supported these service and information programs, including a film, television spots on sudden infant death syndrome, and publications.

A full time staff of 10 persons received responsibility to coordinate the development and implementation of the sudden infant death syndrome program in 1975. A twenty-minute color film was produced which will have widespread impact in increasing public awareness, orienting health and emergency workers and local officials, and for use in training community personnel.

Research and Training: In 1976 anticipated increases in State, local, and private financing will maintain the research and training programs at the 1975 levels. The universities and hospitals which sponsor the 93 research projects and 21 university-affiliated centers will be providing a higher level of matching support for their respective programs. During 1976 assessment will be made of the priorities for the Title V research and training programs. Strategies will be developed and implemented to insure that these activities are consistent with and directly supportive of the priorities and needs of the overall Title V program.

In research, priority is given to projects which show promise of advancing the delivery of maternal and child health and crippled children's services. During 1975 a total of 93 projects were funded. The projects relate to such areas as perinatology, the nutrition of mothers and children, and the development and study of predictive tests for parenting capabilities. Projects of on-going long-term priority are infant mortality, child abuse, pregnancy during adolescence, methodologies for evaluating health service delivery programs, methods to improve the utilization of health professionals, and sudden infant death syndrome.

Two examples of research results follow:

1) The National Academy of Science conducted a study on phototherapy in the treatment of hyperbilirubinemia (jaundice) in the newborn. Major recommendations were made in use of phototherapy and further research to be done.

2) A manual for self-evaluation of maternity and infant care projects has been developed by Case Western Reserve University. The manual has been field tested in 10 projects and is undergoing final revision based on pilot test results.

The university-affiliated centers' program specifically trains health personnel to work with mentally retarded children and the multiply handicapped. The additional trained health manpower contributes to the advancement of the delivery of maternal and child health and crippled children's services. In 1975 the funding base for the university affiliated centers' program was expanded by $1.5 million. In addition, $500,000 was obligated to start a new center in the Southwest, increasing the total number of such centers to 21.

The cumulative number of persons trained under the university-affiliated mental retardation centers' program, 1967 through 1975 was 2,550. The following is a summary of the number of trainees supported in 1975.

Long-term Trainees:

Physicians	60
Nutritionists	9
Pedodontists	26
Medical Social Workers	126
Psychologists	90
Speech Therapists	76
Physical Therapists	20
Others	43
Total	450

The physicians' assistants and nurse practitioners program was initiated in 1972. Through 1975 the cumulative number of persons trained totalled 470. Listed below are the trainees in this program during 1975.

Long-term Trainees:

Pediatric Nurse Practitioners	92
Nurse Midwives	32
Other Physicians' Assistants	26
Total	150

The total number of health personnel receiving training under the Title V training program in 1975 was 600.

Family Planning

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses	---	$100,615,000	---	$79,435,000	---	-$21,180,000
Subactivities:						
(1) Family planning services	---	94,500,000	---	75,135,000	---	-19,365,000
(2) Training and education	---	3,600,000	---	2,300,000	---	-1,300,000
(3) Services delivery improvement	---	2,515,000	---	2,000,000	---	-515,000
Total	---	100,615,000	---	79,435,000	---	-21,180,000

Introduction

Family planning services are designed to provide educational, comprehensive medical and social services to enable individuals to freely determine the number and spacing of their children. In providing these services priority is given to those who cannot afford them. Title X of the PHS Act authorized funds for the support of family planning services, training of family planning personnel, development and distribution of family planning educational materials, and operational research and technical assistance to improve the delivery of family planning services.

It is anticipated that the family planning Title X program together with increased third-party and non-Federal funds will provide services to 1.6 million persons in 1976, the same level as in 1975. This is based on the assumption that increased State and local funding will be available to supplement the resources requested in this budget and that increased efforts to collect third-party reimbursements and to improve project efficiency will continue.

1/ Excludes $409,000 for 1973 appropriation restoration.

Several program initiatives in 1975 were designed to improve project management and quality of care. Program indicators (performance standards) were introduced in order to monitor and where necessary, upgrade the quality of medical services and the efficiency of project operations. In 1976, the quality of services provided will also be addressed by the introduction of ambulatory health care standards which have been developed to improve and maintain quality health care in family planning projects.

In order to better monitor the operations of projects, new reporting requirements also were added to the national reporting system in 1975. During 1976, this improved system will provide the program with better information.

In addition to the new initiatives for project management improvement, efforts have been focused on the collection of available reimbursements, particularly those authorized under Title IV-A and XIX of the Social Security Act. In 1975, an amount of $9.0 million was collected in third-party reimbursements. It is expected that $10.9 million will be collected in 1976.

The 1976 training strategy is to continue to shift from training physicians and specialists to training allied health professionals and paraprofessionals. Continued emphasis will be given to training of project staff at the project site instead of off-site training programs.

In 1976 efforts relating to family planning information and education will continue to be placed on activities designed to reach the high-risk and hard-to-reach populations. A model for the effective delivery of educational family planning services will be developed to meet the special needs of the retarded. Three additional separate studies will be accomplished in 1976: the impact of informed consent on choice of methods; continuation of the program; and subsequent fertility. The Project Teen Concern model will be extended to other areas throughout the country.

In 1976, service delivery improvement activity will focus on developing new and improved techniques and methods to assist family planning programs to increase productivity and to provide services more effectively. The Boston (Region I) automated billing system will be tested in four additional States. Over one-third of the family planning projects will receive assistance in improving their accounting systems in order to increase their ability to obtain third-party reimbursements. Demonstration projects such as specialized information, referral and counseling techniques in rural areas will be tested to increase the effectiveness of delivering family planning services to the hard-to-reach, the disabled and the patient dropout. Other activities will include development of clinic management tools, including self-instruction staff materials, to assist family planning managers in improving clinic operations.

Family planning services: Through 300 grants, services are provided in 2,920 of 3,074 counties in the United States. Grants were awarded to State and local health agencies, hospitals, universities, community agencies and other public or nonprofit entities for the purpose of providing comprehensive family planning services. In 1975, 1.6 million persons were served with funds appropriated under this authority. Services include comprehensive family planning medical, educational, and social services. A medical history, physical examination including a breast examination, and various health screening tests such as a cervical smear for cancer were among the specific services provided. Other services include

patient counseling, education and the provision of contraceptive supplies. According to data from the National Reporting System for Family Planning, 84 percent of all patients were using the more effective methods (oral contraceptives or IUDs).

Training: The objective of family planning training activities is to provide the training necessary to insure that family planning staff will have the skills to effectively deliver voluntary family planning services. Nineteen training grants and contracts totaling $3,000,000 were awarded in 1975.

They provided for the development of management skills for key personnel; the training of service delivery staff; and development of training guides, audiovisual aids, self-instructional courses, and related materials. Approximately, 5,600 personnel involved in the delivery of family planning services received training, including physicians, nurses, health educators, administrators, and office and clinic personnel.

Information and Education: The direction of the program has been to inform the general public of the benefits to be derived from comprehensive family planning services and to support special education programs and activities directed toward the high-risk and hard-to-reach populations. A major objective is to provide direct support to serve projects in developing comprehensive patient education programs.

A national multi-media campaign was launched in 1975, and general informational materials were developed for males, teenagers, young married couples who wish to space their children, and older couples who feel their families are complete. Culturally oriented materials were developed for the Spanish speaking and for American Indians. Emphasis continued on bringing together State leaders and parents to develop strategies for establishing family planning and family life educational programs for the mentally retarded to be carried out by the States.

A model education program has been implemented in a school system to protect junior high students against unwanted conception and venereal disease (Project Teen Concern).

Services Delivery Improvement: Special studies and programs are carried out to support the continued development and improvement of a national family planning program responsive to patients' needs, family planning priorities, significant Regional, State and local variations, and special population groups. The ultimate objective of the research activity is the development of more effective and efficient methods and techniques for the delivery of family planning services.

In 1975, contracts were awarded to expand the Boston (Region I) data system to incorporate an automated billing system to assist in obtaining third-party reimbursements; to implement the family planning evaluation model in all projects; and to conduct a clinic operations study to enable managers to make optimum utilization of clinic time and manpower. Other special studies included projects to test techniques for providing family planning services to the handicapped and to demonstrate the effective utilization of the physician extender in family planning clinics. A special training curriculum for teaching natural family planning methods was also developed for the purpose of improving the capability of Federally funded family planning clinics to serve patients who prefer to practice natural methods of family planning.

Migrant Health

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses	---	$23,750,000	---	$19,200,000	---	-$4,550,000

Introduction

Projects supported under this activity provide health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population. These projects are authorized by Section 310 of the Public Health Service Act. Services provided range from a full complement of diagnostic, therapeutic, and follow-up medical services with provisions for dental care, health counseling, preventive and outreach services to a more limited focus on specific diseases.

In 1976, 390,000 persons will be provided services. This is the same number provided care in 1975. It is assumed that this level can be maintained by continuing the emphasis on collection of third-party reimbursements and making management improvements in program operations, and by requiring increased State, local and private contributions. In 1976, efforts to improve management efficiency, program effectiveness and the quality of care will continue for the maintenance of high quality health care for migrants.

In 1975 program indicators and performance measures were developed to assist the program in identifying program management problems. In 1975 the major improvement in project financial management was the installation of the migrant health cost accounting system. With the use of these cost funding techniques and with improved collections from all available third-party sources, 30 projects in 1976 will increase collections to 8 percent of their total operating costs. Utilizing program indicators developed to provide explicit program management expectations, the productivity and quality of services provided in migrant projects will be increased.

In 1975 services were provided in 37 States and jurisdictions at 355 service sites by 105 projects under 96 grants. Eleven of the projects also provided services through mobile clinics. While fixed location service delivery sites are more desirable, mobile clinics have proved useful under limited circumstances such as for screening, preventive services (immunizations), and categorical services (dental), when there is adequate back-up available at a fixed facility.

The numbers of grants supported and people served in 1975 are as follows:

Number of grants..... 96
Estimated number of patients served...390,000
Estimated number of patient visits....640,000

The uniform utilization and cost data reporting system became operational in all migrant projects in 1975. It provided projects with data to assist in improving their overall fiscal management as well as project analysis. The migrant hospital demonstration program, initiated in 1974, was extended to six additional projects and nine additional hospitals in 1975. This resulted in a total of 12 projects and 17 hospitals participating in the program. Approximately 80,000 migrants had access to hospital care and 2,200 patients were admitted for a total of 8,000 patient days.

In 1975, 5,700 migrants and their dependents were enrolled in programs in Florida and Texas to provide both ambulatory and hospital benefits for migrants during their yearly work cycle. Florida and Texas Blue Cross/Blue Shield plans serve as fiscal intermediaries to reimburse private physicians and hospitals for services provided to the enrolled population. Data from these projects will be used to estimate utilization rates and per capita cost of health services for migrants.

Initiated in 1974, the training of 50 staff members from projects in 9 States was completed in 1975. These personnel from the projects serving the major homebase areas were trained in the recognition of adverse sanitary conditions and violations of Occupational Safety and Health Administration and State migrant labor camp standards. Effective referral of deficiencies to responsible State regulatory agencies for corrective action was emphasized. In addition contracts were implemented with two States, Ohio and New York, in 1975 to assist them in developing intensified migrant labor camp sanitation programs.

Health Maintenance Organizations

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	125	$2,281,000	125	$2,694,000	---	+$413,000
Other expenses	---	65,974,000	---	15,918,000	---	-50,056,000
Total	125	68,255,000	125	18,612,000	---	-49,643,000
Subactivities:						
1. Financial assistance grants & contracts	---	29,658,000	---	15,000,000	---	-14,658,000
Budget Authority	---	(4,658,000)	---	(15,000,000)	---	(+10,342,000)
2. Direct Loan & loan guarantee fund 1/	---	35,000,000	---	---	---	-35,000,000
Budget Authority		(---)	---	(---)	---	(---)
3. Program Support	125	3,597,000	125	3,612,000	---	+15,000
Budget Authority		(3,597,000)	---	(3,612,000)	---	(+15,000)
Total	125	68,255,000 2/	125	18,612,000	---	-49,643,000
Budget Authority	---	(8,255,000) 3/	---	(18,612,000)	---	(+10,357,000)

1/ The loan fund is a revolving fund; therefore, a decrease in appropriation level does not reflect a decrease in program level.

2/ The total obligational level in 1975 for Health Maintenance Organizations is $78,500,000. This includes $25,000,000 for grants and contracts and $35,000,000 for loans and loan guarantees appropriated in 1974 and $18,500,000 ($15,000,000 for grants and $3,500,000 for program support) appropriated in 1975.

A net reprogramming of $10,245,000 leaves a revised obligational level of $68,255,000. The $68,255,000 reflects a total reprogramming from grants and contracts of $10,342,000 of which $97,000 is for program support pay (Cont'd)

2/(Cont'd) raise in the health maintenance organization activity and $10,245,000 is for bonus pay and pay raise in other health services appropriation activities.
3/ The total budget authority in 1975 is $18,500,000. This includes $15,000,000 for grants and contracts and $3,500,000 for program support. Of this amount, a net of $10,245,000 is proposed for reprogramming. This leaves a net budget authority of $8,255,000.

Introduction

Health Maintenance Organizations (HMOs) provide comprehensive health services on a prepaid capitation basis in accord with the definition contained in P.L. 93-222. The Health Maintenance Organization Act provides for:

1. Grants and contracts for feasibility surveys.
2. Grants, contracts, and loan guarantees for planning and for initial development costs.
3. Loans and loan guarantees to cover initial operations deficits for the first three years of operations.
4. Continued regulation of HMOs qualified for participation in "dual-choice" access to employer/employee health care markets.

An appropriation of $18,612,000 is requested for the health maintenance organization program in fiscal year 1976.

In the table which follows, the $15,000,000 for grants available from this request, is supplemented by $3,000,000 in carry-over funds from the 20 percent "rural set-aside" of the fiscal year 1975 appropriation which we do not currently have plans to obligate. Furthermore, a request for a one-year extension to the five-year authorization of the health maintenance organization program is being submitted. If approved by the Congress, this one year extension will permit continued funding in 1976 of feasibility, planning, and initial development grants. The 1976 budget request, then, will support a greater number of projects at a lower annual level for a longer period, as demonstrated:

	1975		1976	
	No.	Amount	No.	Amount
Feasibility	101	$5,000,000	20	$1,000,000
Planning	33	4,100,000	75	6,000,000
Initial Development	31	10,900,000	30	11,000,000
"Rural set-aside"	--	3,000,000	--	--
Contingency	--	6,658,000	--	--
	165	29,658,000 1/	125	18,000,000 2/
Loans for Initial Operation	8	35,000,000	29	--
Program Support	--	3,597,000	--	3,612,000
Total	173	$68,255,000	154	$21,612,000

1/ Excludes $10,245,000 proposed for reprogramming for pay raise and bonus pay for activities within the Health Services appropriation.
2/ Includes $3,000,000 rural set-aside carryover from 1975 which is not part of the 1976 request nor included in obligation estimates on the previous tables and schedules.

Feasibility Studies (Section 1303): Funds totaling $1,000,000 are requested to provide grant or contract support in 1976 for approximately 20 new organizations to study the feasibility of developing an HMO. The average amount of each award is approximately $50,000.

Planning and Initial Development (Section 1304): Funds totaling $6,000,000 are requested to provide grant or contract support in 1976 for approximately 75 planning projects, at $80,000 per award. Also, $8,000,000 is requested for about 22 projects in the initial development stage. In addition, 8 projects in the initial development stage will be supported from the $3,000,000 rural set-aside carry-over which is not part of this request. These awards are made at a maximum of $1,000,000 and an average of approximately $367,000 each for developmental activities during this fiscal year. Loan guarantees will be available to profit-making HMOs for these activities.

The amount needed to support an HMO in its planning and initial development stages depends on the nature of the organization. Some (such as established multi-specialty group practices) require a relatively small amount to convert to HMO status. For others, the total costs will probably be higher. For example, a hospital-based group practice that develops an HMO may need 20,000 to 30,000 enrollees before reaching the break-even point. This formidable marketing challenge requires substantial funds for initial development.

Direct Loan and Loan Guarantee Fund: Loans for public or non-profit private HMOs and loan guarantees for profit-making HMOs are authorized under Section 1305. These may not exceed $1,000,000 in any fiscal year of $2,500,000 total for the first three years of operation. An estimated 29 new HMOs will each receive $1,000,000 loans from the fund in 1976. Using the assumption of approximately 30,000 enrollees per HMO, the 29 new HMOs will eventually serve approximately 870,000 people. The fund will be replenished by sale of the loans. Once sold, the Federal Government guarantees the payment of principal and interest to the purchaser of the loan.

Program Support: For fiscal year 1976, $3,612,000 and 125 positions are requested for program support. These positions will provide administration of the grant and loan programs, qualification of HMOs, continued regulation of qualified HMOs and monitoring of the implementation of the dual choice provisions of Title XIII. Coordination with other Federal agencies, States and organizations in the private sector will continue.

During 1975 an estimated 165 grants will be made - 101 for feasibility studies, 33 for planning, and 31 for initial development. It is estimated that grants will be awarded to sponsorship organizations as follows: 12 universities, 80 community organizations, 21 hospitals, and 52 physician groups in about 40 States. Loans will be made to eight organizations to assist them in defraying initial operating expenses.

Several factors have combined to reduce the funds expended in 1975 from the anticipated level, although the number of projects funded is essentially at the planned 1975 level.

1. The average cost of applications and awards has been significantly less than the amounts previously projected.
2. The stringency of the Act and of the regulations to implement it required rigid criteria to be set for funding, with the result that some organizations which applied for substantial development funds could receive no more than planning awards.
3. The economic climate undoubtedly deterred organizations from starting new undertakings, even with Federal start-up assistance.
4. Many well qualified prospects which could have entered at the developmental level delayed participation until all regulations were published so that the full extent of the obligations under the Act would be known.
5. Emphasis on staffing and training early in the program did not permit extensive outreach activities to stimulate program interest.

An effort has been in progress since December to identify potentially successful sponsors through Regional Office outreach as well as through direct contacts with organizations such as American Group Practice Association, American Association Foundation for Medical Care, National Association of Blue Shield Plans, Group Health Association of America, Inc., and State and county medical societies. This effort, coupled with the publication of the qualification and dual option regulations is expected to increase markedly the volume of program participation.

Section 1310 of the HMO Act requires employers of 25 or more persons who offer health benefits plans to include the choice of membership in a qualified HMO, if one is available, to their employees. This section of the Act will be implemented through the dual-choice regulations. Regulations and procedures were developed to allow the recognition and designation of qualified HMOs - those HMOs in conformance with P.L. 93-222. Such HMOs, as well as those which have received assistance under the Act, are subject to continued regulation by the Department.

National Health Service Corps

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	405	$10,063,000	405	$10,461,000	---	+$398,000
Other expenses	---	2,068,000	---	2,068,000	---	---
Total	405	12,131,000	405	12,529,000	---	+398,000

Introduction

The National Health Service Corps was established in 1971 to improve the delivery of health services to persons living in communities and areas of the United States where health personnel and services are inadequate to meet their health needs. To alleviate the critical health manpower shortage, the Corps recruits and places health teams consisting of physicians, dentists, nurses and allied health professionals in shortage areas. The Corps seeks to improve health services in communities not only by providing temporary help but principally by helping these areas plan and build their own systems of health care.

Corps personnel help communities apply for assistance from the program. The application must include certification of need from State and local health societies and recommendations from other health agencies. The applicant community is required to arrange for adequate facilities, equipment, hospital privileges and consulting arrangements.

The Corps has emphasized the development of an effective long term recruitment program for provider personnel, especially physicians. Through an organized campaign of visits to over 100 medical schools, exhibits at 15 professional meetings, 9,000 letters to prospective assignees, over 100 advertisements in 7 professional journals, plus 2 special mailings to 52,000 house officers (physicians in post-graduate training programs - interns and residents), the Corps has increased its recruitment of physicians and dentists from 14 in 1971 to 260 in 1975. In 1975, considerable refinement was achieved in the process of matching assignees to communities. Data on every approved community is available through the National Health Service Corps data bank. Each candidate is matched with a least four sites in two regions which most closely resemble preferences expressed by the applicant; this process will be repeated, if necessary, until satisfaction with the choices is expressed. After telephone assessment of all four sites, the applicant has the option of selecting and visiting one the sites. Based on both applicant and community needs and preferences, the most acceptable match

1/ Includes $2,896,000 proposed reprogramming from the HMO activity for Bonus Pay.

51-805 O - 75 -- 16

is made. This interchange of information minimizes the possibility of future dissatisfaction of either party. In 1975, 500 of these matching site visits occurred.

A major activity has been the provision of assistance to community groups in setting up programs that link assignees to other provider units. Considerable improvement in the continuing medical education program and quality of care assessment were implemented. These programs greatly improve the possibility of the health provider's remaining in the community. The Corps' retention rate for 1975 was 26 percent compared to 3 percent in 1973.

As the following table indicates, the 1976 budget provides for continuation of the Corps at the same level as in 1975:

	1974 Actual	1975 Estimate	1976 Estimate
Field Assignments:			
MD	242	264	264
DDS	55	71	71
RN, Others	108	70	70
Total	405	405	405
Communities	193	180	180
People Served	450,000	600,000	600,000

In 1975, the Corps has approved 445 sites for Corps assistance and has placed 405 doctors, dentists, nurses and other health professionals in 180 communities in 40 States. It has experimented successfully with utilizing physician extenders (nurse practitioners and physicians' assistants) to provide health services. The presence of Corps personnel has drawn other health professionals to areas which were medically underserved.

The following table illustrates the progress made and anticipated by the Corps:

	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
People served	400,000	450,000	600,000	600,000
Areas designated as eligible	183	681	1,000	1,200
Sites Approved	240	323	445	495
Sites Staffed	183	193	180	180
States Served	42	40	40	40
Self-Sustaining Sites	--	10	48	60
Independent Sites	3	34	60	94
Non-Federal support personnel hired at sites	--	600	780	780
Recruitment advocates developed in over 100 medical schools and 300 training programs	--	--	400	500
Inquiries about program from physicians and dentists	500	1,500	9,700	15,000

Quality Assurance

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	322	$6,230,000	340	$7,109,000	+18	+$879,000
Other expenses	---	34,529,000	---	47,573,000	---	+13,044,000
Total	322	40,759,000	340	54,682,000	+18	+13,923,000

Introduction

The Bureau of Quality Assurance provides national leadership and direction to efforts to assure that health care services provided under the Medicare, Medicaid, and other Federal programs are medically necessary and furnished in the most economical manner consistent with recognized professional standards of care, and serves as the national focus for assuring accountability to health care consumers for the quality of health care services.

A nationwide network of 203 physician-sponsored Professional Standards Review Organizations (PSRO's) will be established to assure quality of care and to assure appropriate utilization provided to the beneficiaries of the Medicare, Medicaid and Maternal and Child Health programs.

Through the Medical Care Standards program the Bureau provides the professional health expertise necessary for implementing the Department's responsibilities, through standards setting and enforcement, for assuring the health and safety of Medicare and Medicaid beneficiaries.

Included with the Bureau's Medicare-related responsibilities are those in connection with the medical aspects of the End-Stage Renal Disease (ESRD) program. One of the major objectives is the provision for total health care needs associated with treatment of ESRD. This will be centered around approximately 700 facilities providing ESRD care which will be organized into 29 networks.

1/ Includes proposed reprogramming of $72,000 from HMO's to cover bonus pay.

Medical Care Standards

	Estimate[1]		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	167	$3,518,000	167	$3,555,000	---	+$37,000
Other expenses	---	1,037,000	--	982,000	---	-55,000
Total	167	4,555,000	167	4,537,000	---	-18,000

Introduction

Through a delegation from the Secretary, DHEW, the Bureau of Quality Assurance (BQA), has principal responsibility for the professional health aspects in carrying out the quality assurance provisions of Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act. As an ongoing activity, BQA provides consultation to the Social Security Administration's Bureau of Health Insurance (BHI) and the Social and Rehabilitation Service (SRS) in the process of development, interpretation, assessment, and modification of Medicare and Medicaid health and safety standards, policies and methods for the certification of providers participating in these federally financed programs. The standards must be continuously evaluated and revised to assure their validity, and upgraded to reflect advances in current medical care practices and technology. A primary objective of the Bureau is to improve the capability of health care providers to deliver quality services by utilizing Medicare/Medicaid statutory authority for establishing and maintaining effective standards and by strengthening federally supported State survey agencies in carrying out their provider certification functions.

The Bureau directs its standards and certification responsibilities largely as a decentralized program. Policy and program development activities are performed mainly by Central Office, whereas program implementation and execution are responsibilities of the ten regional offices and State survey agencies. Uniform certification procedures have been established and issued as Federal regulations and serve as the basis for providers and suppliers of health care services to participate under the Medicare and Medicaid programs. A current listing of Medicare/Medicaid providers and suppliers follows:

Hospitals	
Acute and Rehabilitation	6,750
Psychiatric	353
Skilled Nursing Facilities	7,150
Intermediate Care Facilities	9,189
End-Stage Renal Disease Facilities	700
Home Health Agencies	2,286
Independent Laboratories	3,030
Outpatient Physical and Speech Therapy Services	116
Portable X-Ray Services	113

To help ensure effective application of Medicare/Medicaid quality standards, physicians, nurses, laboratory specialists and other health services professionals assigned to Regional Offices provide continuing assistance and consultation to

1/ Includes proposed reprogramming of $72,000 from HMO's to cover bonus pay.

State survey agencies and Regional staff of the Bureau of Health Insurance, SSA, and the Medical Services Administration, SRS. The resulting improvement of facilities and services has benefited not only the over 50 million Medicare/Medicaid beneficiaries, but care to the total population has been upgraded.

Consultation is also provided to the Social Security Administration on a continuing basis in the development of policies and procedures not related specifically to standards for providers or suppliers, but which have an impact on quality or delivery of service. This assistance deals with the approval or disapproval of Medicare coverage to include new drugs, medical equipment and devices and diagnostic and therapeutic procedures; coverage determination of emergency hospitalization at non-participating hospitals; and participation in provider appeals and hearings proceedings.

In 1976 implementation of ESRD regulations will be monitored; operating policies and procedures for medical review boards and network coordinating councils will be issued; and ESRD program activities of other Federal agencies will be integrated into the program. An important activity in 1976 will be integrating planning for ESRD with the new planning agencies to be established. These activities will be centered around approximately 700 facilities providing ESRD care which will be organized into about 29 networks. Approximately 18,500 patients will be served now and 50,000 to 60,000 patients when the program reaches its "steady state" in about 10 years.

ESRD networks will be a mechanism by which an integration of hospitals and other health facilities providing ESRD care will be organized in order to foster an effective system of delivery. Such a system will promote resource accessibility as well as coordinated patient referral. Each facility within a network will be represented on a Network Coordinating Council which will be required to establish a Medical Review Board to review the ESRD care provided within that network. Networks will also be required to provide all the treatment modalities necessary for ESRD care.

During 1976, ambulatory health care standards will be further refined and efforts will be made with the Bureau of Health Insurance to establish them as conditions of participation for a Medicare provider of service.

New regulations covering Medicare/Medicaid utilization review (UR) requirements were issued and implemented in 1975. In 1976, a concerted effort will be made to coordinate the UR regulations and their application with the Professional Standards Review Organization (PSRO) operations.

A major objective in 1976 will be to conduct a comprehensive evaluation of surveyor training activities. This will include a close review of current training programs, assessment of skills and knowledge needed by surveyors, and a reoriented program to fill the identified training needs.

Program review has become a major continuing process for monitoring and evaluating the effectiveness of the application of the Medicare/Medicaid provider standards by State survey agencies. During 1975 and 1976, Regional validation teams composed of representatives from the Bureau of Quality Assurance, Bureau of Health Insurance, and the Regional Directors' Long-Term Care Standards Enforcement units will conduct in-depth evaluation of each State's Medicare and Medicaid certification operations. In addition, quarterly visits to States and validation surveys of providers of care by Regional staff, for purpose of monitoring performance and to provide consultation and assistance, will be a major effort both in 1975 and 1976. In 1976, emphasis will be on implementation of more stringent standards for independent and hospital laboratories, with special attention to

internal quality control measures and proficiency testing to assure reliable laboratory services.

A major responsibility, under P.L. 92-603 (Section 299I) is the End-Stage Renal Disease program. In 1975, regulations to implement the long-range program will be proposed and planning for a national patient transplant and dialysis medical data system and outcome registry will be conducted. Development of the conditions of participation for the long-range program will be completed and ESRD networks will be proposed. In addition, the regulations for the long-term program will be finalized.

New health and safety standards for hospitals, independent laboratories, and End-Stage Renal Disease facilities, will be issued in 1975 and their implementation will be in progress in 1976. Central and regional program staff will continue to provide consultation to State agencies focusing on standardized survey procedures, manuals, and guidelines for the implementation and interpretation of standards and certification policies, covering not only hospital, laboratory, and ESRD services, but also for long-term care services provided by skilled nursing and intermediate care facilities.

Ambulatory health care standards developed by the Bureau will be applied by program staff in 1975 in over 150 operational center projects funded by the Bureau of Community Health Services.

The Department's responsibility for providing a mechanism of professional qualification, other than formal education requirements, to designated categories of health personnel under Medicare/Medicaid will continue through calendar year 1977 as prescribed by P.L. 92-603. Proficiency examinations developed by nationally recognized professional testing organizations will be administered in 1975 and 1976 to the following types of health personnel: physical therapists, practical nurses licensed by waiver, cytotechnologists, clinical laboratory technologists, psychiatric technicians and radiologic technicians. In 1976, an evaluation will be designed to measure the effectiveness of this proficiency testing program.

Training efforts for State survey personnel will continue in 1975 to encompass a more integrated and complete program. Concentrated efforts will be on standardized orientation for Federal and State survey and certification personnel, with programmed instruction utilized where applicable. Advanced and specialized training courses will be provided to sharpen the techniques and skills of surveyors and consultants in improving provider performance, particularly in the areas of laboratory, renal disease and long-term care services. Special courses for surveyors of laboratories will be accelerated in 1975 and 1976 with the Center for Disease Control as the principal training resource.

A total of $4,537,000 is requested for this activity. This represents a net decrease of $18,000 from the 1975 level of operations. This amount is composed of a $72,000 reduction in other expenses to cover bonus pay, partially offset by a $54,000 increase for annualization costs of the October 1974 pay raise. This program is funded in its entirety by reimbursements to this account from the Social Security Trust Funds.

Professional Standards Review Organization

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	155	$2,712,000	173	$3,554,000	+18	+$842,000
Other expenses	---	33,492,000	---	46,591,000	---	+13,099,000
Total	155	36,204,000	173	50,145,000	+18	+13,941,000

Introduction

The Professional Standards Review Organization (PSRO) program was authorized by the 1972 amendments to the Social Security Act. The PSRO provision of Public Law 92-603 (Section 249F) requires the Secretary to establish and support a nationwide network of voluntary, nonprofit groups of local physicians to assure the quality and appropriate utilization of health care services financed by and provided to beneficiaries and recipients of Medicare, Medicaid, and Maternal and Child Health programs. The purpose of the statute is twofold: (a) to improve the quality of health care services; and (b) make more cost effective the expenditures for health care services financed by Titles XVIII, XIX, and V of the Social Security Act. PSRO's are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local physician organizations, State Councils, and a National Council supported and evaluated by the Federal Government.

PSRO's will review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of the level, duration, and methods of treatment. In reviewing medical necessity and quality, PSRO's will be determining whether health care services provided are necessary on the basis of professionally developed standards and norms of care, diagnosis, and treatment. In reviewing appropriateness, PSRO's must determine whether health care services are provided at the most efficient and effective level. This peer review system will assure that payment is made from Federal and state funds for only medically necessary, appropriate, and quality care.

The PSRO Legislation requires PSRO review of services furnished by hospitals and other health care institutions such as skilled nursing facilities and intermediate care facilities. The review of other types of health care, such as ambulatory care, may be undertaken at the option of the individual PSRO and with the Secretary's approval.

The PSRO program relates closely to and must be integrated with other health care review activities required by the Social Security Act particularly as the Act was amended in 1972. The PSRO legislation intends that utilization review and other related duplicate review activities will eventually be eliminated and PSRO's will assume responsibility for such activities. To this end, the final utilization review regulations published in November 1974 for Medicare and Medicaid were designed to facilitate effective institutional review capability and thereby expedite the establishment of the PSRO program.

PSRO activities during 1976 will focus on the following major objectives: continuation of the conditional PSRO's initiated in 1974 and 1975; converting a limited number of planning PSRO's to conditional status, and funding up to 3 Statewide Councils; continued funding of planning PSRO's not yet converted to conditional status; assisting the 13 Support Centers to become financially self-sufficient (no funds will be directly budgeted for Support Centers in 1976 - Support Centers will be expected to arrange subcontracts with the PSRO's); implementation of all regulations issued during 1975; and coordination of the End-Stage Renal Disease (ESRD) and PSRO programs.

FY 1976 activities relating to review in long-term care facilities will require the development of policies, operational plans, and administrative arrangements; policies on ambulatory care will be designed; and continued integration of other review activities such as utilization, medical, and independent professional review with PSRO activities.

Another important objective for 1976 relates to the evaluation of the impact of the PSRO program on the quality and utilization of health care services financed under Medicare, Medicaid, and Maternal and Child Health programs. Savings in length of stay and unnecessary admissions as the result of PSRO activities will be assessed.

Implementation: In 1974 the country was divided into 203 PSRO areas designated by the Secretary of DHEW. Late in 1974, 102 areas were funded with 11 conditional PSRO's and 91 planning PSRO's. Of the 203 areas, over 75% have less than 2,000 physicians; about 65% of the areas have populations of 1 million or less; and only about 10% have over 2 million.

Conditional PSRO's: The eleven conditional PSRO's funded in late FY 74 and the two funded by mid-FY 75 began operation of their review systems in short-term general hospitals. The hospital peer review system that these PSRO's are responsible for implementing is an integrated one, which includes concurrent review, medical care evaluation studies and profile analysis. Concurrent review includes admission certification and continued stay review. The review is based on the use of explicitly stated norms, criteria, and standards, established by the physicians in each PSRO area. This review essentially replaces existing third-party payment review and potentially eliminates retroactive denial having to do with the quality, appropriateness and necessity of services.

In order to conduct review in these hospitals, the conditional PSRO's: (1) are developing memoranda of understanding with the Medicare intermediaries and Medicaid agencies; (2) are developing memoranda of understanding with each hospital in which review is initiated; (3) have and continue to establish norms and adopt or adapt criteria and standards; (4) are evaluating and determining capability of each hospital to carry out its own review; (5) are delegating and monitoring review to capable and willing hospitals and conducting review in other hospitals; (6) are continuing to recruit physician members; (7) are working with non-physician practitioners and (8) are developing internal operating procedures and accounting systems and training reviewers and other personnel.

By the end of 1975, about 30-40 of the existing 91 planning PSRO's will be converted to conditional PSRO status. The remaining organizations will require additional time to meet the qualifications for conditional designation and to the extent that is financially feasible the qualified ones will be converted during 1976. Examples of conditional PSRO activity are as follows:

(1) The Utah PSRO is presently performing admission certification and continued stay review on 100% of the elective and emergency admissions in 21 of the 38 hospitals in the State. Between June 18, 1974, and November 30, 1974, UPSRO had reviewed 10,489 PSRO patients. A formal Memorandum of Understanding has been executed with the Utah Medicaid Agency, and an interim agreement has been signed with the Medicare intermediary. The Utah PSRO has 1,108 members. This figure represents 67% of the licensed physicians in the State. The physician committees of Utah PSRO have developed critical criteria for 125 diagnoses. UPSRO currently has six Medical Care Evaluation Studies in progress.

(2) The Wyoming PSRO is presently performing admission certification and continued stay review on 100% of the elective and emergency admissions covered under Titles XVIII, XIX, and V in all 37 hospitals in the State. Between September 20, 1974 and January 11, 1975, the PSRO reviewed 5,413 PSRO admissions. During this period, they were phasing-in review activity on a hospital-by-hospital basis. Current review activity is approximately 3,000 admissions per month. The PSRO has signed a Memorandum of Understanding with the Medicaid agency and an interim document with the Medicare intermediary. The PSRO has 320 members out of an eligible 360 physicians. Physician committees have developed critical criteria for 104 diagnoses, and have two Medical Care Evaluation Studies in progress.

(3) The Colorado Foundation for Medical Care (CFMC) is presently performing admission certification and continued stay review on 100% of the elective admissions covered under Titles XVIII, XIX, and V in all 90 of the acute care hospitals in the State. Between July 1, 1974 and January 31, 1975, CFMC reviewed 69,379 PSRO admissions. The current review activity is approximately 10,000 admissions per month. The Foundation has signed interim Memoranda of Understanding with the Title XVIII and XIX programs. A memorandum with the Title V program is expected soon. The Foundation has a current membership of 1,719 out on an eligible population of 3,580 physicians.

Planning PSRO's; Support Centers; Support Contracts: Up to 20 new planning PSRO's will be funded in F.Y. '75. The planning PSRO's initially funded in F.Y. '74, which must be carried over to 1976, will, of course, require continued funding. The 13 PSRO Support Centers which were funded in 1974 will be continued in 1975. These are for the most part State level physician organizations providing technical assistance to planning and conditional PSRO's. In addition, several contracts have been awarded to develop critically needed technical resources for the PSRO program. For example, there is a contract with the American Medical Association, which is subcontracting with most of the major specialty societies, to develop critical screening criteria for concurrent review. In addition, a training contract has been awarded to the Institute for Professional Standards to train PSRO administrators and reviewers.

Policy and Regulations: The complex operational nature of the program, coupled with statutory requirements, results in the need for a significant array of policies and regulations. The PSRO Manual initially published in April 1974 and since updated and expanded, contains interim program policies which are guiding the PSRO's. Many of these and additional policies will be published as regulations in 1975. These include: hospital review responsibilities; norms; the hearings and appeals process, confidentiality of PSRO data; correlation of functions between PSRO and Medicare, and Medicaid; Statewide PSR Councils; selection of Advisory Groups; and sanctions. In addition, PSRO reimbursement policies will be issued.

Management Information System: To assure accountability, monitoring, sound management and evaluation, a uniform information and reporting system will be implemented in 1975 which will include cost data, performance data on review activities, and overall administrative and management data.

Integration of PSRO and New Utilization Review Regulations: The PSRO Manual indicates that PSRO's are to give priority to the review of inpatient hospital care. On November 29, 1974, final regulations were issued implementing improvements to utilization review (UR) procedures in Medicare and Medicaid. The UR amendments require hospitals to carry out a system of concurrent review and medical care evaluation studies essentially the same as that to be used in the PSRO program. The PSRO law provides for PSRO's to rely on the review activities of those hospital UR committees which the PSRO determines are functioning effectively. The implementation of an integrated approach to PSRO and UR has been a significant activity in 1975.

In summary, the 1976 budget request of $50,145,000 and 173 positions represents an increase of $13,941,000 and 18 positions over the 1975 level of operations. The increase is composed of $759,000 to cover mandatory items, $270,000 for support of 18 new positions and $12,912,000 for PSRO contracts. The funding for the PSRO program is between direct appropriated funds in the amount of $30,011,000, and reimbursable funds from the Social Security Trust Funds in the amount of $20,134,000.

Patient Care and Special Health Services

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits.....	5,896	$94,661,000	5,218	$91,596,000	-678	-$3,065,000
Other expenses.....	---	44,693,000	---	45,137,000	---	+444,000
Total.....	5,896	139,354,000	5,218	136,733,000	-678	-2,621,000
Reimbursable obligations.....	---	20,903,000	---	21,265,000	---	+362,000
Direct obligations....	---	118,451,000	---	115,468,000	---	-2,983,000

Introduction

This program provides direct and contract health care to the legal beneficiaries of the Public Health Service. Major beneficiary groups are American seamen, personnel and dependents of the Coast Guard and the Public Health Service Commissioned Corps, Federal employees' compensation cases and persons with Hansen's disease. Health care is provided for participants and certain spouses and children of participants in the Public Health Service study of untreated syphilis initiated in 1932. On a reimbursable basis, care is provided through PHS hospitals and outpatient clinics to foreign seamen, beneficiaries of other Federal agencies, community residents, and through Federal employee health units to employees of the Federal government.

1/ Includes proposed reprogramming of $5,767,000 from Health Maintenance Organizations to cover pay increase and bonus pay.

Patient Care

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits.....	5,479	$86,767,000	4,801	$83,580,000	-678	-$3,187,000
Other expenses.....	---	36,273,000	---	36,753,000	---	+480,000
Total.....	5,479	123,040,000	4,801	120,333,000	-678	-2,707,000
Reimbursable obligations.....		15,169,000		15,169,000		---
Direct obligations....		107,871,000		105,164,000		-2,707,000

The primary mission of this program is to provide comprehensive health care to Public Health Service beneficiaries. On a reimbursable basis, health care is also provided in PHS hospitals and outpatient clinics to foreign seamen, beneficiaries of other Federal agencies, and community residents.

The program operates eight general medical and surgical hospitals, most of which have training and research programs, and the National Leprosarium at Carville, Louisiana. In addition, the system operates 26 outpatient clinics, purchases health services in four outpatient clinics, and contracts with about 200 physicians and dentists to provide health care to ambulatory patients. When PHS facilities are not readily accessible, beneficiaries receive care in other Federal and non-Federal facilities. Training programs are established for interns and residents as well as for allied health personnel. Research programs include both clinical and health services research. Some clinical research is financed by grants from other Federal agencies, such as the National Institutes of Health.

This program has been operating the PHS hospitals and outpatient clinics under the mandate of Public Law 93-155, which provides that the PHS hospitals continue to furnish all patient care services at the operating level of January 1, 1973, unless Congress approves a proposed change. Health care for beneficiaries will be continued within a restricted budget. An assessment of our medical facilities will be made to determine possible alternative mechanisms for delivering care at a reduced cost. Development and presentation of legislative proposals to the Congress may be required. In 1976, there will be a reduction of 285 positions, and related funds, which will be taken in non-patient care areas, where possible. The remaining reduction of 393 positions, and related funds, reflects the termination on July 1, 1975, of the 1975 Congressional increase for this activity.

Patient Care: Patient care workloads for 1975 are estimated as follows:

Average daily patient load (ADPL) in PHS hospitals	1,648
Outpatient visits to:	
PHS hospitals	846,000
PHS outpatient clinics	709,000
Contract care:	
ADPL in non-PHS hospitals	86
Visits to contract physicians	69,300

Training: Presently in training are 150 medical residents, 85 medical interns, 43 dental residents and 12 pharmacy residents. Thirty-seven physician assistants are being trained for patient care employment in the hospitals and clinics. In addition, PHS facilities provide on-the-job experience to about 5,000 allied

health personnel, both PHS employees and others from universities, colleges, and health institutions. These personnel receive training in health careers such as nursing assistants, dental hygienists and assistants, orthopedic assistants and laboratory technicians. About 40 employees receive support for long-term training in universities and colleges to increase their professional competence.

Research: Research activities currently conducted in PHS hospials include both clincial and health services research. Clinical research activities are concerned primarily with major disease problems of the United States, such as cardiovascular disease, cancer, and chronic kidney disease. Health services research projects are directed toward improving the quality, efficency, and economy of the delivery of health services.

1/ Includes proposed reprogramming of $5,310,000, from Health Maintenance Organizations to cover pay increase and bonus pay.

Coast Guard Medical Services

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits.....	151	$3,772,000	151	$3,796,000	---	+$24,000
Other expenses.....	---	4,988,000	---	4,702,000	---	-286,000
Total.....	151	8,760,000	151	8,498,000	---	-262,000

The budget provides for medical services to Coast Guard personnel aboard their vessels and at their air and other shore stations. It also provides for care in contract medical facilities, for hospitalization in Federal facilities other than those operated by the Public Health Service, and for emergency medical treatment in non-contract facilities as authorized by law. Not included in this budget for medical services are costs funded by the Coast Guard such as space, utilities, medical and dental equipment, mobile dental units, furniture, office appliances, and pay and travel allowances of Coast Guard personnel assigned to the program.

Full-time medical, dental, and ancillary staff are assigned where sufficient concentrations of personnel exist to make operation of such facilities economical to the Government. When USPHS facilities are inaccessible, contract care is provided through utilization of civilian or other Federal agency health care facilities. Drug abuse and alcohol rehabilitation programs provide for the prevention of problems in these areas as well as for detection, treatment, and rehabilitation of personnel with these problems. In addition, the major recruit training centers are operating facilities to rehabilitate personnel with minor psychological disorders. An attempt is being made to broaden the scope of the health care delivery system to include industrial, environmental, aviation, and underwater medical services.

Health care facilities of the Coast Guard medical program are as follows:

Major shore facilities	10
Minor shore facilities and dispensaries	84
Mobile dental units	9
Vessels	
High endurance cutters and icebreakers	20
Small ships	59
Total facilities	182

1/ Includes proposed reprogramming of $416,000 from Health Maintenance Organizations to cover pay increase and bonus pay.

Federal Employee Health Services

	1975 Estimate 1/		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits.....	266	$4,122,000	266	$4,220,000	---	+$98,000
Other expenses.....	---	2,232,000	---	2,482,000	---	+250,000
Total.....	266	6,354,000	266	6,702,000	---	+348,000
Reimbursable obligations.....		5,734,000		6,096,000		+362,000
Direct obligations.		620,000		606,000		-14,000

Responsibility for Federal employee health is assigned to the Public Health Service under P.L. 79-658, August 8, 1946 (5 USC 7901), and the Bureau of the Budget Executive Circular No. A-72, June 18, 1965.

In 1976, it is expected that over 100 health units will be operating under this activity, providing occupational health services to an estimated 190,000 Federal employees. This continues the level of operation reached during 1975. The services authorized include emergency diagnosis and treatment of injury or illness occurring during working hours; pre-employment examinations; inservice examinations determined necessary by the Department or agency head; administration of treatments and medications in certain circumstances; preventive services to appraise and report work environment health hazards; health education and specific disease screening examinations and immunizations; and referral to private physicians, dentists, and other community health resources. The specified goal is provision of these services for all Federal employees who work in groups of 300 or more.

The Division of Federal Employee Health has established the following objectives:

a. To provide consultation on the organization and establishment of employee health services to any Federal agency requesting advice; to provide standards and criteria for the provision of such employee health services; and, when requested, to assist agencies of the Government in the evaluation of such services.

b. To organize, administer, and operate Federal employee health services for participating Federal agencies on a reimbursable basis.

1/ Includes proposed reprogramming of $41,000 from Health Maintenance Organizations to cover pay increase and bonus pay.

Payment to Hawaii

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses.....	---	$1,200,000	---	$1,200,000	---	---

Federal legislation was passed on June 25, 1952, providing for payments to the Board of Health of the State of Hawaii for the care and treatment in its facilities of persons with Hansen's disease. Funding for this program began in F.Y. 1953 in the amount of $500,000; from F.Y. 1954 thru F.Y. 1960, $1,000,000 was appropriated each year, and since F.Y. 1961, $1,200,000 has been appropriated annually.

It should be noted that because reimbursement is based on actual expenses, the amount requested will not be paid unless it is actually needed. Any expenses above the $1,200,000 will be borne by the State of Hawaii.

The table below shows the estimated average daily patient load, patient days, per diem cost, and appropriation requests for 1975 and 1976.

	1975	1976
Average daily patient load.....	140	134
Patient days.....	50,949	48,893
Inpatient per diem cost.....	$37.68	$42.99
Total inpatient cost.....	$1,920,000	$2,102,000
Total outpatient cost.....	50,000	54,000
Total cost.....	1,970,000	2,156,000
Appropriation request.....	$1,200,000	$1,200,000

Buildings and Facilities

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses.....	---	$21,697,000	---	$3,729,000	---	-$17,968,000
Budget authority....	---	($1,300,000)	---	(---)	---	(-$1,300,000)

This activity includes all proposed direct construction items of the Health Services Administration except construction of Indian health facilities. The 1976 estimate provides for the continued upgrading of PHS facilities with funds appropriated in prior years. No new funds are requested.

Emergency Medical Services

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses...	---	$37,000,000	---	$25,100,000	---	-$11,900,000
Subactivities:						
(1) Section 1202-Feasibility Studies and Planning.....	---	4,875,000	---	3,400,000	---	-1,475,000
(2) Section 1203-Establishing and Initial Operation....	---	19,500,000	---	13,600,000	---	-5,900,000
(3) Section 1204-Expansion and Improvement.....	---	8,125,000	---	5,600,000	---	-2,525,000
(4) Section 1205-Research.....	---	4,500,000	---	2,500,000	---	-2,000,000
Total.....	---	37,000,000	---	25,100,000	---	-11,900,000

Introduction

The Emergency Medical Services Systems program, Title XII of the PHS Act, provides for the coordination of personnel, facilities, and equipment for the effective delivery of emergency health care services within a geographical area. At the community level this program may be administered by a public or nonprofit entity which has the authority and the resources to provide effective administration of the systems.

Federal assistance is provided for the implementation of emergency medical service systems. To obtain assistance in setting up a system, the administering agency must provide evidence that local support will continue after Federal funding is terminated.

Each Emergency Medical Services system shall contain numerous functional components that will provide for a system that is easily accessible, regardless of the patient's ability to pay, the geographic location, the time of day, or the type of medical emergency.

Four types of programs will be funded: (1) feasibility studies and planning; (2) establishment and initial operation; (3) expansion and improvement; and (4) research.

Legislative authority for the program expires June 30, 1976 but a proposal is being submitted that would extend the authorities of the Emergency Medical Services Systems Act. In addition, a proposed modification would delete the provisions which restrict funding for EMS initial operation grants.

51-805 O - 75 -- 17

In 1976, the Emergency Medical Services program will have provided for the development, on a cumulative basis, of 76 emergency medical service system areas serving a potential population of 38,000,000 persons.

Not less than 20 percent of this request will be made available in grants and contracts for the development of emergency medical service systems that will serve rural areas. This qualification does not apply to Research programs.

It is estimated that 15 to 20 percent of deaths due to traumatic injury and heart attack can be prevented. This would mean 60,000 lives saved annually by improved emergency medical services. The Emergency Medical Services Systems program will be accomplished through the following activities:

Feasibility Studies and Planning (Section 1202): An amount of $3,400,000 will provide for an estimated 75 grants or contracts to be awarded in 1976 to establish feasibility studies and planning programs for States, regional jurisdictions and local communities. Each grant or contract award will be approximately $45,000.

Establishment and Initial Operation (Section 1203): An amount of $13,600,000 will provide for an estimated 19 grants or contracts to be awarded in 1976 for the establishment of Emergency Medical Services Systems at an average cost of $700,000 for each grant or contract award. The Federal government will provide about 50 percent of the obligations for first year awards and 25 percent for second year awards. The Federal share may go as high as 75 percent for first year awards and 50 percent for second year awards if the recipient demonstrates an exceptional need for financial assistance.

Expansion and Improvement (Section 1204): An amount of $5,600,000 will provide for an estimated 14 grants or contracts to be awarded in 1976 for the expansion and improvement of existing Emergency Medical Service Systems. Each grant or contract award will be approximately $400,000. The Federal government will provide 50 percent of the obligations for expansion and improvement grants or contracts, or as much as 75 percent if the recipient demonstrates an exceptional need for financial assistance.

Research (Section 1205): An amount of $2,500,000 will provide for the continuation of the emergency medical services research program during 1976. It is anticipated that 13 grants or contracts can be awarded at an average cost of $185,000 for research in emergency medical techniques, methods, devices, and service delivery.

During 1975, model Emergency Medical Service Systems were operational in communities throughout the nation. Selective evaluation data are available from several of these systems:

(1) calls to a Poison Control Center have increased 40% while emergency admissions from poisoning have decreased by 38%.

(2) the survival rate for neonatal infants was 75-77%.

(3) in one metropolitan system formerly 10.3% of patients with chest pain would deteroriate in route to the hospital and 5.1% would die. With the system, these percentages have decreased to 3.8% and 1.0%, respectively. This represents a five fold decrease in heart attack deaths.

(4) in a small city, good system care has resulted in a 15.5% reduction of coronary deaths, and

(5) improvements have also been reported for deaths from traumatic injury. One state system reported a 29% decrease in deaths from vehicle accidents.

The following table indicates the estimated number of grants or contracts to be awarded in 1975 and 1976, the total amounts available for obligation, and the amounts available to rural areas under each section of the Emergency Medical Services Systems Act.

Type of Grant or Contract	1975			1976		
	No. of Grants or Contracts	Amounts Available Total	Amounts Available Rural	No. of Grants or Contracts	Amounts Available Total	Amounts Available Rural
Feasibility studies and planning.....	108	$4,875,000	$2,680,000	75	$3,400,000	$1,870,000
Establishing and initial operation.....	27	19,500,000	10,140,000	19	13,600,000	7,072,000
Expansion and improvement.....	20	8,125,000	2,519,000	14	5,600,000	1,736,000
Research.....	24	4,500,000	1/	13	2,500,000	1/
Totals.....	179	37,000,000	15,339,000	121	25,100,000	10,678,000

1/ The EMSS Act provides that special consideration should be given to applications for research relating to the delivery of emergency medical services in rural areas.

Program Management

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..	917	$19,639,000	907	$19,764,000	-10	+$125,000
Other expenses.....	---	14,012,000	---	9,805,000	---	-4,207,000
Total.....	917	33,651,000	907	29,569,000	-10	-4,082,000
Subactivities:						
Bureau of Community Health Services....	633	22,310,000	623	19,090,000	-10	-3,220,000
Bureau of Medical Services.....	119	3,798,000	119	3,658,000	---	-140,000
Office of the Administrator.....	165	3,766,000	165	3,595,000	---	-171,000
Payment to GSA.....	---	3,777,000	---	3,226,000	---	-551,000
Total.....	917	33,651,000	907	29,569,000	-10	-4,082,000

Introduction

The purpose of the program management activity is to administer and provide program support to the Bureau of Community Health Services and the Bureau of Medical Services programs, to provide for the payment of rent to the General Services Administration, and to support the Office of the Administrator which plans, directs, and administers the programs of the Health Services Administration.

For 1976 there is proposed a net decrease of $4,082,000 and 10 positions. This consists of a decrease of $3,266,000 as follows: $2,222,000 for technical assistance to health service delivery projects, $750,000 for Maternal and Child Health Services for the Indian people, and $294,000 for National Health Service Corps related contracts. In addition, there is a decrease of $50,000 which is related to the 10 position reduction in the National Health Service Corps and a decrease of $2,315,000 including a 90 manyear reduction. These decreases totaling $5,631,000 are offset by mandatory increases for pay raise and related items of $559,000 for a net decrease of $4,082,000.

a. Bureau of Community Health Services:

The purpose of this subactivity is to provide national leadership and direction to legislatively mandated programs, and to provide full support to the decentralized grant programs of the Bureau of Community Health Services.

The headquarters staff is responsible for the development of policies and regulations governing these health care delivery programs, applied research and training, improving the financial aspects of the program such as maximizing third-party reimbursements, and planning, monitoring and analysis activities to improve program management.

The regional staff has primary responsibility for grant and project administration. The regional staff also provides technical assistance and program guidance to existing and potential grantees.

In 1976 high priority will be given to increasing third-party collections in the Community Health Centers, Maternal and Child Health, Family Planning and Migrant Health programs. This will be accomplished by strengthening financial management and project efficiency through the utilization of program indicators and reporting requirements in order to increase reimbursements from existing payments mechanisms such as Medicaid, Medicare and private insurance. In addition, efforts will be made to increase State and local matching funds to 20% above the 1975 level in order to maintain the 1975 level of services.

The National Health Service Corps will continue the assignment and support of 405 health professionals and allied health workers in communities designated as critical health manpower shortage areas. The Corps will continue to strengthen its relationships with professional associations and community organizations.

b. Patient Care and Special Health Services:

The purpose of this subactivity is to administer and provide support to the Patient Care and Special Health Services programs as well as Emergency Medical Services and other Bureau of Medical Services programs. Professional personnel assigned to the DHEW Regional Offices serve as the initial contact point for response to State and local inquiries concerning the Emergency Medical Services program; promote the development of emergency medical services systems; and provide technical assistance to State and local communities in developing grant and contract proposals.

c. Health Services Administration, Office of the Administrator:

The 1976 request for this subactivity includes $3,595,000 and 165 positions. It supports a central staff necessary to planning, direction and administration of the broad scope of programs and activities in the Health Services Administration. Support is provided the Administrator in the formulation of policies and program plans, and in evaluating Agency progress in mission accomplishment. Also, staff assistance is provided in the areas of contracts and grants administration, financial management, personnel management, property management, legislative services, communications and public affairs, equal employment opportunity, and general services.

In addition, the Office of the Administrator will provide policy and program leadership, and monitor and evaluate progress in achieving ongoing program objectives related to the provision of health care to

Indians and Alaska Natives and to other Federal beneficiaries. The Office of the Administrator will also provide policy guidance in the areas of standards setting for quality assurance activities, implementation of the Professional Standards Review Organization program and in the overall management of the family planning, maternal and child health, neighborhood health centers, National Health Service Corps and Federal employee health programs.

d. Payments-General Services Administration:

This budget proposes $3,226,000, a reduction of $551,000. The reduction is based on estimated collections from other agencies for rent related to reimbursable activities for 1976.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services - Community health centers (PHS Act, Section 314(e))

1975 Estimate 1/		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$196,648,000	2/	---	$155,190,000

Purpose: This program provides a mechanism for meeting special health needs of regional and national significance in the development and support of ambulatory health care services programs. Community health centers provide primary health care and arrange for specialty and inpatient care primarily for people who live in medically underserved areas.

Explanation: Under Section 314(e) of the PHS Act, project grants are awarded to public or non-profit private agencies, institutions or organizations to support ambulatory health service programs which provide primary care and develop arrangements for the provision of specialty and inpatient care.

Accomplishments in 1975: In 1975, 157 community health centers provided a range of preventive, therapeutic, and rehabilitative ambulatory services to an estimated 1,425,000 persons. Due to improved overall management capabilities, third-party reimbursements increased 20 percent of total annual operating costs compared to 17 percent in 1974. The introduction of program indicators based on reporting requirements enabled management to make improved project management and funding decisions in 1975. Ambulatory health care standards were developed and surveys of all centers have been conducted thus enabling the centers to achieve and maintain a high level of quality services.

Objectives for 1976: Efforts to improve management efficiency, program effectiveness and the quality of care will continue.

We will increase assurance of care effectiveness by the establishment of ambulatory care standards which will be met by all community health centers. This added assurance of care quality will allow major third-party payors to adopt a policy of full reimbursement for services rendered by the centers to their clients.

The $155,190,000 requested in 1976 together with the expected increased funding from State, local and private voluntary organizations, will provide health care to approximately 1,425,000 people.

1/ Excludes $313,000 for 1973 appropriation restoration.
2/ Authorization expired June 30, 1974.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services — Comprehensive health grants to States (PHS Act, Section 314(d))

1975 Estimate		1976	1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
63	$90,000,000	1/	---	---

Purpose: These formula grants are awarded to State public health authorities to assist in the establishment and maintenance of adequate public health services in accordance with priorities and goals established by the States.

Explanation: Under Section 314(d) of the PHS Act, grant allocations are based on a State's population and per capita income.

Accomplishments in 1975: Program areas for which these funds were used include chronic disease programs, environmental health services, laboratory services, home health and public health nursing services and community mental health services. The 63 Federal positions were utilized to supplement State staff in tuberculosis control activities, venereal disease programs, family planning, epidemiology, data collection and analysis, and related areas.

Objectives for 1976: Because 314(d) funds allocated to State health authorities constitute only approximately four percent of the reported expenditures of State Health departments and because it is anticipated that States will be able to make alternative arrangements for continued support of high priority programs supported by these funds, the Department is requesting no funds in 1976.

1/ Authorization expired June 30, 1974.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Maternal and child health grants to States (Social Security Act as amended through 1967, Sections 503, 504 and 516)

1975 Estimate			1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
58	$266,951,000	Indefinite by Activity 1/	---	$193,922,000

Purpose: The maternal and child health program enables each State to extend and improve services for reducing infant mortality and promoting the health of mothers and children. The program also is designed to develop and improve services for locating and diagnosing children who suffer from crippling diseases or potentially crippling conditions, and then providing them with medical care and aftercare.

Explanation: Section 503, Maternal and Child Health Services, and Section 504, Crippled Children Services, provide for grants to States on a formula basis to deliver appropriate services. Grants also are authorized to State agencies and public or non-profit institutions of higher learning for special projects of regional or national significance which contribute to the health of mothers and children, including crippled and mentally retarded children. In both formula grant programs, one-half of the amount appropriated for each Section is apportioned among the States on a population-related formula basis. From the remaining half of the appropriation, specified amounts are reserved for special project grants and the balance is apportioned by formula (inverse population and per capita income ratio) among the States.

Accomplishments in 1975: In 1975 P.L. 93-53 terminated the grant authority to fund projects in five categories: Maternity and Infant Care, Comprehensive Health for Children and Youth, Intensive Infant Care, Dental Care for Children and Youth, and Family Planning. The new law incorporated into Section 503, Maternal and Child Health, Formula Grants to States, those funds which were previously obligated under the project grant authority. The result is that 90 percent of the Maternal and Child Health appropriation now is being apportioned as formula grants to States.

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000

P.L. 93-53 mandated that each State will implement the five categories of services to residents within the State. The maternal and child health program provided technical assistance to 56 jurisdictions to meet the requirement; 163 new projects were either implemented or their plans finalized and incorporated into the State plans for maternal and child health services.

The transition of project grant authority from the maternal and child health program to the State health agencies was completed in 1975 and the 210 projects which were funded in 1974 under project grant authorities continued to receive support under the State agencies. As required by Section 516 of P.L. 93-53, no States received less funds in 1975 under the 90 percent formula grant program than their 1973 total of formula plus project grants.

NUMBERS OF PEOPLE SERVED*
(in thousands)

	1975
Mothers receiving prenatal and postpartum care	600
Women receiving family planning services	1,968
Children attending well-child conferences	1,805
Crippled children receiving physician services	550
Children registered for comprehensive services	568
Children receiving dental treatment	984
Infants admitted to comprehensive services	166
Pediatric Pulmonary Centers	31
Children receiving nursing services	3,063
Children Screened:	
Visual screening	9,846
Audiometer testing	6,564
Dental screening	3,282
Immunizations (include booster and revaccinations):	
Polio	3,008
Rubella	3,282
Diphtheria	3,282

- Provided mental retardation clinical services to over 70,000 children; services include diagnosis, evaluation, development and implementation of management plan, follow-up care. Also provided screening services under State maternal and child health programs to identify children with conditions which might lead to mental retardation, refer to special clinics.

- Provided partial support to 10 Pediatric Pulmonary Centers, served over 30,000 children suffering from chronic pulmonary disease, e.g. cystic fibrosis, asthma; the Centers also serve as training sites for professionals: physicians, registered nurses, medical social workers. Training programs address treatment etiology, special problem in treatment, as examples.

*Non-add

Objectives for 1976: Continued emphasis will focus on improving financial management, data collection, and cost-finding techniques. The projects started in 1975 and those previously supported under project grant authority will continue to receive technical assistance which will prepare them to become providers of services under insurance and public health care financing programs, e.g. Medicare, Medicaid.

- Continue support of mental retardation special clinics; assist them in obtaining additional State, local, and private financing and third-party reimbursements from Medicare, Medicaid, private health insurance.

- Federal support of pediatric pulmonary centers will be discontinued in 1976.

- No support is requested for the 58 positions added to this activity in 1975.

- Efforts to improve management efficiency and program effectiveness will continue for the maintenance of high quality health care primarily for those who live in medically underserved areas.

- Continue to serve 9.4 million persons, assuming increased levels of State, local, and private support to meet the reduction in Federal funds.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Maternal and child health -- Sudden infant death syndrome (Title XI, PHS Act as amended, 1974)

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
10	$2,000,000	$2,000,000	---	---

Purpose: This program is designed to introduce an awareness of Sudden Infant Death Syndrome, also known as crib death, among health providers, and also to develop more effective ways of assisting families following the loss of a child.

Explanation: Through grant and contract arrangements, informational materials are developed and disseminated to health providers and the affected public.

Accomplishments in 1975: Provided consultation to communities with interest in implementing local sudden infant death syndrome programs.

- Awarded 30 grants to implement service programs which will offer counseling, increase awareness of community emergency service personnel, strengthen linkages between community agencies, e.g., police and fire departments and coroner's offices.

- Disseminated information on sudden infant death syndrome through television spots, publications.

- Participated on Sudden Infant Death Syndrome Interdepartmental Committee.

- Produced a color film for information and education.

Objectives for 1976: Federal funds are not being requested in 1976 to support the sudden infant death syndrome program. As part of the overall effort to reduce the level of Federal spending, State and local governments are being asked to provide support for this program as part of their increased effort in the area of maternal and child health services.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Maternal and child health research and training
(Social Security Act as amended through 1967, Section 511 and 512)

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$25,917,000	Indefinite by Activity 1/	---	$17,500,000

Purpose: The research program supports projects which show promise of contributing to the advancement of maternal and child health and crippled children services. High priority is placed on projects which can improve the effectiveness of comprehensive health care programs which utilize varying levels of trained health personnel.

The training program provides for multidisciplinary training to increase the health manpower with special skills for working with the crippled and multiply handicapped.

Explanation: The University-Affiliated Centers program provides multidisciplinary training for specialists who will work with mothers and children, particularly mentally retarded children or those suffering from multiple handicaps. These centers have developed effective programs of prevention, treatment, and rehabilitation. Grants to public or non-profit institutions of higher learning provide support for faculty, traineeships, services, clinical facilities, and short-term institutes and workshops. At each center the faculty, representing over 20 professional disciplines, provides a full range of clinical services as well as the setting to train future professionals. Within individual centers programs are designed to meet the professional needs of the trainees, including language development and disorders of handicapped children, methods for integrating the retarded child into regular schools, and feeding clinics and workshops for nutritionists and dietitians who will work with handicapped children.

Research grants and contracts are made with research organizations and public or private non-profit agencies to conduct research concerning mothers and children in all classes of our society. High priority is given to solving special problems faced by population segments which do not receive adequate health care.

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.

Accomplishments in 1975: In 1975 research activities supported 68 projects, addressing such areas as child abuse, adolescent pregnancy, improving utilization of health personnel, sudden infant death, evaluation of delivery programs, perinatal care, nutrition of mothers and children, and predicative tests for parenting capabilities.

- From 1967 to 1975 the cumulative number of persons trained under the University-Affiliated Mental Retardation Centers program was 2,550.

- The cumulative number of persons trained through 1975 under the Physicians Assistants and Nurse Practitioners Programs, started in 1972, was 470.

The following summarizes the number of trainees supported in 1975 under both programs:

- Supported training for 600 trainees:

1. University-Affiliated Mental Retardation Centers (20 Centers)

Long-term Trainees:	
Physicians	60
Nutritionists	9
Pedondontists	26
Medical Social Workers	126
Psychologists	90
Speech Therapists	76
Physical Therapists	20
Others	43
Subtotal	450

2. Physicians Assistants and Nurse Practitioner Programs

Long-term Trainees:	
Pediatric Nurse Practitioners	92
Nurse Midwives	32
Other Physicians Assistants	26
Subtotal	150
Total	600

Objectives for 1976: The current level of research and training will be continued in 1976, assuming that additional State, local, and private financing will become available to supplement the funds being requested as a part of this appropriation. Emphasis will be placed on increased private foundation or university support from the sites where research and training projects are located.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Family planning project grants and contracts (PHS Act, Title X)

1975 Estimate 1/		1976 Authorization	1976 Budget Estimate	
Pos.	Amount		Pos.	Amount
---	$100,615,000	2/	---	$79,435,000

Purpose: The goal of the family planning service program is to provide a full range of high quality family planning services to people who want such services but for financial or other reasons do not have access to them.

Explanation: Project grants are made under Title X of the PHS Act to State and local health departments and other public or nonprofit organizations to provide family planning services. Title X authorizes project grants and contracts for the training of family planning workers, studies of new and improved methods of delivering family planning services, and the development and distribution of family planning educational materials.

Accomplishments in 1975: The program provided family planning services to 1.6 million patients in 1975. Improved management resulted in the collection of $9 million in third-party reimbursements and reduced administrative costs from consolidation activities completed in 1974. In addition, program indicators (performance standards) were introduced in order to monitor and, where necessary, upgrade the quality of services and the management of programs. Approximately 5,600 family planning workers, physicians, nurses, administrators, office and clinic personnel received short-term training in order to upgrade and improve their administrative and service delivery skills and knowledge.

The information and education activity was directed to inform the general public and to support special education programs and activities for high-risk and hard-to-reach populations. A national mu'ti-media campaign was launched, and general informational materials were developed. Special educational activities included the development of informational and educational materials for the Spanish speaking and for American Indians, regional meetings of State leaders and parents to develop strategies for establishing State programs for the mentally retarded, and testing of a model educational program for junior high school students. Research activity emphasized the development of more effective methods and techniques for delivering family planning services and provision of assistance to grantees in implementing research findings and results. Some of the 1975 activity

1/ Excludes $409,000 for 1973 appropriation restorations.
2/ Authorization expired June 30, 1974.

included the following: demonstrating the effective utilization of the physician extender in family planning, testing techniques for delivering services to the handicapped, implementing a family planning evaluation model in all projects, developing a Region-wide automated billing system prototype, conducting a clinic operations analysis, and developing a training curriculum in natural family planning methods.

Objectives for 1976: It is anticipated that the family planning Title X program together with increased third-party and non-Federal funds will provide services to 1.6 million persons in 1976, the same number as in 1975. This assumes that efforts to improve program efficiency and to collect third-party reimbursements will be continued. In addition, emphasis will be placed on increased State and local contributions. In 1976, emphasis will be placed on improving project management productivity, and the quality of services provided. Ambulatory health care standards will be implemented in all projects. A technical assistance program will be conducted to assist projects in implementing these initiatives.

The emphasis in training will be to provide short-term training primarily to allied health and paraprofessional personnel at the clinic site instead of off-site training locations. Information and education activity will target on the high-risk and hard-to-reach population, and will include a family planning educational model for the retarded. Special studies of informed consent education and the impact on patients' choice of methods, continuation in the program and subsequent fertility will be conducted.

The services delivery improvement strategy will continue to stress the development and implementation of more effective methods of delivering services and managing family planning programs. Projects will receive technical assistance in implementing study and demonstration findings. Demonstration projects to test more effective service delivery methods for the hard-to-reach, disabled and patient dropouts will be developed, along with improved methods to enable the family planning program and clinic managers to improve program operations.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Migrant health
(PHS Act, Section 310)

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$23,750,000	1/	---	$19,200,000

Purpose: This program provides access to health care services for migrant and seasonal farmworkers and their families.

Explanation: Under Section 310 of the PHS Act, support is provided to finance part of the costs (no specific matching requirement) of establishing family health services clinics and to improve the health services and health condition of agricultural migrant workers and their families by providing health care services.

Accomplishments 1975: An estimated 390,000 persons received services in 1975. This involved approximately 640,000 medical encounters (about 1.6 per person). Through program management efforts, the uniform utilization and cost data reporting system was implemented.

Initiated in 1974, a special project to support services, gather data, and identify cost and utilization patterns provided access to previously unavailable hospital services for approximately 80,000 migrants. Twelve projects and 17 hospitals participated in this program in 1975 and 2,200 patients were admitted for a total of 8,800 hospital days.

A two part sanitation activity resulted in

(1) the training of 50 project personnel from 9 States to recognize and improve labor camp sanitation conditions, and

(2) contractual agreements with two States to provide staff work exclusively in migrant sanitation.

In 1975, 7,700 migrants and their dependents were enrolled in programs in Florida and Texas to provide both ambulatory and hospital benefits to migrants during their yearly work cycle.

Objectives for 1976: In 1976 the program will:

(1) support the continued development of health services to serve migrant and seasonal farmworkers. The proposed budget of $19,200,000 will be used to provide services to 390,000 persons currently being served. These funds will be supplemented by increased, State, local financing and third-party reimbursement.

(2) continue implementation of program to improve environmental sanitation.

(3) implement medical care quality and project management improvement program.

1/ Subject to extension of PHS Act, Section 310, which expired June 30, 1974.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services - Health maintenance organizations (PHS Act, Section 301 and Title XIII)

	1975 Estimate 1/		1976		
				Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
Budget Authority.....	125	$ 8,255,000	2/	125	$18,612,000
Obligations.....	125	68,255,000		125	18,612,000

Purpose: The Health Maintenance Organization Act of 1973 (P.L. 93-222) provides authority for a five-year program of assistance to promote the development of new and expansion of existing health maintenance organizations (HMOs). The legislation is based on the concept that assistance to HMOs is one of the more effective means of dealing with specific major problems in health care today, such as:

-- the rapid inflation in medical care
-- the inadequate emphasis on illness prevention
-- an increasing unevenness in the distribution and quality of medical care.

HMOs provide comprehensive health services on a prepaid capitation basis in accord with the definition contained in the HMO Act.

Explanation: Financial assistance is provided to public and private non-profit HMOs by grants and contracts for feasibility studies, planning and, initial development. The revolving loan and loan guarantee fund was capitalized with $35,000,000 from fiscal year 1974 appropriations and no additional funds are requested. This fund will help cover operating deficits during the first three years of an HMO's operation. Profit-making HMOs are eligible for loan guarantees for planning, development and initial operating costs if they will serve medically underserved populations. Priority for all types of assistance will be given to HMOs which will serve such populations; 20% of the funds are set aside for rural HMOs. In the request, $3,612,000 is for program support which includes the support of 125 positions.

1/ Excludes $10,245,000 proposed for reprogramming for pay increase and bonus pay for all activities within the Health Services appropriation.
2/ Financial assistance grants and contracts (1309(a)), $55,000,000; direct loans (1309(b)), $75,000,000 in the aggregate for 1974 and 1975; loan guarantees (1308(d)), indefinite; program support (301), indefinite.

Accomplishments in 1975: The 1975 grant activity has proceeded concurrently with the drafting and publication of regulations and guidelines to implement the legislation. A total of 101 feasibility studies at a cost of $50,000 each, 33 planning activities at $125,000 each and about 31 initial development projects at approximately $367,000 each will have been initiated.

Grantees in 1975 represent approximately 21 hospitals, 80 community groups, 52 physician groups, and 12 universities and include both urban groups (132) and groups from non-metropolitan areas (33) distributed among 40 States. In addition, 40 of those funded plan to serve medically underserved populations. Eight loans for initial operations will be placed. These eight HMOs should provide services to approximately 240,000 enrollees at maturity.

Program support activities carried out during 1975 included training of about 80 new staff, development of all key regulations for implementing the Act and provision of technical assistance to 15 States considering enabling legislation. These activities also include implementation of processes for application review and award, the award of 173 initial and continuation awards of financial assistance, the implementation of the loan program, provision of technical assistance to about 325 developing HMOs, and initiation of HMO qualification. Liaison was established with Federal and State agencies responsible for the purchase of health care to Medicaid beneficiaries.

Objectives for 1976: The loan fund will assist about 37 operational HMOs, including eight beginning operations in 1975. The 37 HMOs will eventually serve approximately 1,110,000 people. Grants will be awarded to assist new HMOs to begin development and to continue support for those projects funded in 1975. Qualification of HMOs eligible for the dual choice provisions of Title XIII (requirement that most employers offer their employees the option of membership in a qualified HMO), and liaison with the Department of Labor to assure employer cooperation with those provisions will be expanded.

HEALTH SERVICES ADMISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- National health service corps (PHS Act, Section 329, as amended)

1975 Estimate		1976	1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
405	$12,131,000	1/	405	$12,529,000

Purpose: The purpose of the National Health Service Corps is to help alleviate the critical health manpower shortage by providing health professionals to communities where shortages exist.

Explanation: This activity is responsible for the recruiting and assigning of appropriate health personnel to critical health manpower shortage areas and assisting communities in the development of self-sufficient local health delivery systems.

Accomplishments in 1975: In 1975, there were 405 health professionals (264 doctors, 71 dentists, 62 clinical nurses and nurse practitioners, and 8 other allied health personnel) assigned to 180 communities in 40 States.

During 1975, the National Health Service Corps more clearly defined its program functions and strengthened its relationships with professional associations and community groups. The confrontation of problems with management of sites, principles of medical practice, community support in the form of equipment and supplies, and review and evaluation of Corps sites resulted in the development of useful procedures in program operations. The Corps will continue to develop and improve regulations, policies and procedures, as well as criteria for community designation. Program activities continue to assist community sites in developing self-sustaining capabilities to manage a local primary care delivery system.

Emphasis has been placed on developing an effective long-term recruitment program for provider personnel with special emphasis on physician recruitment. A major activity has been assisting community groups in setting up programs that link assignees to other provider units. These programs, which foster improved systems of care and develop professional and personal relationships, will greatly improve the possibility of the health providers remaining in the community. The Corps' retention rate for 1975 was 26 percent compared to 20 percent in 1974 and 3 percent for 1973. Because of improved matching techniques and community assistance activities, this rate should increase in 1976.

1/Authorization expired June 30, 1974

Objectives for 1976: This request will continue the support of 405 health professionals in approximately 180 communities in 40 States with critical health manpower shortages. Emphasis will be placed on the recruitment and placement of board eligible physicians instead of interns for 80 percent of new physician positions. Efforts will be made to integrate the NHSC staff with other programs (Community Health Centers, Migrant Health, Indian Health Service) to develop stronger rural health delivery systems. The billing system at sites will continue to be improved. One hundred new sites will be developed and filled while technical assistance to the 180 operational sites will continue to be improved.

	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
People served	400,000	450,000	600,000	600,000
Areas designated as eligible	183*	681	1,000	1,200
Sites Approved	240	323	445	495
Sites Staffed	183	193	180	180
States Served	42	40	40	40
Self-Sustaining Sites	--	10	48	60
Independent Sites	3	34	60	94
Non-Federal support personnel hired at sites	--	600	780	780
Recruitment advocates developed in over 100 medical schools and 300 training programs	--	--	400	500
Inquiries about program from physicians and dentists	500	1,500	9,700	15,000

*Designated under 1970 Statute by placement of personnel

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Quality assurance -- Medical care standards (PHS Act, Sections 301 and 311)

	1975 Estimate 1/		1976		
				Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
Budget Authority	---	$268,000	---	---	---
Obligations	167	4,287,000	Indefinite	167	$4,537,000

Purpose: The Bureau of Quality Assurance provides the professional health expertise necessary for implementing the Department's responsibilities, through standard setting and enforcement, for assuring the health and safety of Medicare and Medicaid beneficiaries, through the appropriateness and quality of services provided to such beneficiaries.

Explanation: This activity provides for the development of specialized programs related to medical care administration, including the professional health aspects of Title XVIII of the Social Security Act. The Bureau accomplishes its objective by participating with the Bureau of Health Insurance (SSA) and the Medical Services Administration (SRS) in the development, interpretation and evaluation of program regulations, policies and procedures, and in the field administration of such program requirements.

Accomplishments in 1975: Revised and strengthened Utilization Review regulations have been published; health and safety standards for hospitals and independent laboratories will be issued; ambulatory health care standards will be applied in over 150 operational health center projects funded by the Bureau of Community Health Services.

Examinations will be offered to license waivered practical nurses, cytotechnologists and clinical laboratory technologists, physical therapists, radiologic technicians and psychiatric technicians not meeting Medicare's formal professional qualifications.

Training efforts for State surveyor personnel will continue to encompass a more integrated and complete program.

Staff will continue to orient State agencies with respect to the new standards and regulations for hospitals, laboratories, skilled nursing and intermediate care facilities and other providers of service.

For the End-Stage Renal Disease program networks will be identified, conditions of participation for networks will be issued and efforts will be initiated to certify facilities and networks for participation in the ESRD program.

Objectives for 1976: An evaluation program will be designed to measure the effectiveness of the proficiency examination program for health personnel.

1/ Includes proposed reprogramming of $72,000 from HMO's to cover bonus pay.

Ambulatory health care standards will be further refined and efforts will be made with the Bureau of Health Insurance to establish them as conditions of participation for a provider of service under Medicare.

Concerted effort will be made to coordinate Utilization Review regulations with PSRO operations.

A major objective will be to conduct a comprehensive evaluation of surveyor training activities. This will include close review of current training programs, assessment of skills and knowledge needed by surveyors, and a reoriented training program to fill the identified training needs.

An important activity will involve coordination of Professional Standards Review Organization (PSRO) and ESRD functions. Since much of ESRD care is delivered in or under the auspices of an institutional facility, the local PSRO's will have responsibility to work closely with the network medical review boards to assure appropriate review of the care provided to all ESRD patients.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Quality Assurance -- Professional standards review organizations (Social Security Act as amended, Title XI, Part B)

	1975 Estimate		1976		
				Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
Budget Authority..	---	$9,124,000	Indefinite	---	$30,011,000
Obligations.....	155	36,204,000	---	173	50,145,000

Purpose: To assure, through the application of suitable procedurres of professional standards review, that the services financed by Titles XVIII, XIX, and V of the Social Security Act will conform to appropriate professional standards for the provision of health care. To promote the effective, efficient, and economical delivery of health care services or proper quality for which payment may be made.

Explanation: The PSRO program was authorized by the 1972 amendments to the Social Security Act (Public Law 92-603). The PSRO provision of that Act (Section 249F) requires the Secretary to establish and support a nationwide network of voluntary, nonprofit groups of local physicians to regulate the quality and costs of health care services financed by and provided to beneficiaries and recipients of Medicare, Medicaid, and Maternal and Child Health programs. PSRO's objectives are to accomplish this by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

Accomplishments in 1975: PSRO activities will focus on such major objectives as development and issuance of program regulations; conversion of about 30-40 existing planning contract organizations to conditional status, the funding of up to 20 new planning PSRO's; the establishment of about 2-3 Statewide Councils, and continued funding of about 13 Support Centers; integration of new utilization review regulations with PSRO's; provision of extensive technical assistance to developing PSRO's; and development and implementation of a PSRO Management Information System.

Other program activities will be the development and issuance of Manual chapter guidelines including reimbursement principles, implementation of the PSRO minimum data set (UHDDS), coordination and implementation of the PSRO monitoring system, and development of an implementation plan for long-term care and ambulatory care review.

Objectives for 1976: Implement all regulations issued during 1975; coordinate the End-Stage Renal Disease (ESRD) and PSRO programs; evaluate the impact of the PSRO program on the quality and utilization of health care services financed under Medicare, Medicaid, and Maternal and Child Health programs; and develop policies, operational plans and administrative arrangements for review in long-term care facilities.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Patient care (PHS Act, Titles III, V, XI and XIII)

1975 Estimate 1/		1976	1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
5,479	$107,871,000	Indefinite	4,801	$105,164,000
Obligations				
5,479	123,040,000		4,801	120,333,000

Purpose: The primary purpose of this program is to provide for the comprehensive health care of American seamen, Coast Guard and PHS Commissioned Corps personnel, and persons with Hansen's disease. On a reimbursable basis, health care is also provided in PHS hospitals and outpatient clinics to foreign seamen and beneficiaries of other Federal agencies and community programs.

Explanation: To carry out this mission, funds have been appropriated to operate Public Health Service hospitals and clinics and, where necessary, to provide for care of primary beneficiaries through contractual arrangements with other Federal and non-Federal hospitals, and with private physicians and dentists. Medical care is also provided on a reimbursable basis to beneficiaries of other Federal agencies and community programs.

Accomplishments in 1975: Health care is being made available to an estimated 500,000 PHS beneficiaries, in addition to foreign seamen and beneficiaries of other Federal agencies and community programs. In the hospitals, there will be a daily average of 1,648 inpatients and an annual total of 1,555,000 outpatient visits to PHS facilities. Contract care in other Federal and non-Federal facilities will average 86 inpatients per day; in addition, there will be 69,000 outpatient visits to private physicians and dentists.

Objectives for 1976: The budget for 1976 will support the continuation of comprehensive care for PHS beneficiaries. An assessment of our medical facilities will be made to determine possible alternative mechanisms for delivering care at a reduced cost. Development and presentation of legislative proposals to the Congress may be required.

1/ Includes proposed reprogramming of $5,310,000 from Health Maintenance Organizations to cover pay increase and bonus pay.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Coast Guard medical services (PHS Act, Section 326)

1975 Estimate 1/		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
151	$8,760,000	Indefinite	151	$8,498,000

Purpose: The Coast Guard Medical Program, under the direction of the Chief Medical Officer, U.S. Coast Guard, provides for delivery of health care to personnel who support the operational mission of the Coast Guard at its air and shore stations and aboard its vessels. Coast Guard personnel are also provided inpatient, outpatient, and emergency medical care and services on a contractual basis in areas not served by PHS facilities and for patients requiring special care.

Explanation: Appropriated funds are used to finance the provision of health care through a system of medical facilities classified as dispensaries and sick bays, and through contract with other hospitals, physicians, and dentists. Where sufficient concentrations of personnel exist, large dispensaries with full-time medical, dental and ancillary staff provide comprehensive care to authorized beneficiaries. Smaller concentrations of personnel are served by smaller dispensaries and sick bays which may have medical and dental officers assigned or may be staffed by Coast Guard hospital corpsmen. In many instances, small concentrations of personnel are provided health care by local contract physicians, dentists, and hospitals, as well as through utilization of Federal medical facilities where available. The Coast Guard operates one accredited hospital located at the Coast Guard Academy, New London, Connecticut.

Accomplishments in 1975: In 1975, care is made available to approximately 122,000 Coastguardsmen (active duty and retired) and their dependents. Outpatient medical and dental visits by all beneficiary classifications will exceed 610,000. A total of approximately 16,000 inpatient days will be recorded in Coast Guard medical facilities. Currently, care is being provided for 100 patients a year, for four months each, at alcoholic rehabilitation centers.

Objectives for 1976: Objectives in 1976 will be to meet the needs of the beneficiary population of approximately 122,000. Programs started in prior years will be continued. Efforts to improve the effectiveness of health care delivery in pursuit of these objectives will continue.

1/ Includes proposed reprogramming of $416,000 from Health Maintenance Organizations to cover pay increase and bonus pay.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Federal employee health services

1975 Estimate 1/		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
266	$620,000	Indefinite	266	$606,000
Obligations				
266	$6,354,000		266	$6,702,000

Purpose: This program operates health units providing selected services for Federal agencies on a reimbursable basis. Appropriated funds provide for consultation and advice to Federal agencies on establishment of occupational health programs and for survey and evaluation of existing occupational health programs, when requested.

Explanation: Prior to establishing a Federal employee health program, all Federal agencies must, by law, consult with the Public Health Service regarding program standards. The appropriated funds provide consultation services for any Federal agency, on request, on the establishment or evaluation of Federal employee occupational health programs. Within its capabilities, the Public Health Service also provides, under reimbursable authority, direct clinical health services to Federal agencies on request.

Accomplishments in 1975: In 1975 over 100 consultations to Federal agencies, executive boards, and associations will be provided on the evaluation and establishment of Federal employee health activities. Occupational health care services are provided for approximately 190,000 Federal employees in 106 health units.

Objectives for 1976: The request for 1976 will permit maintenance of employee health activities at the same level reached in 1975. The program will continue to be responsive to other Federal agencies requesting consultation and evaluation of their occupational health programs. It will also continue operation of 106 health units providing services for approximately 190,000 Federal employees.

1/ Includes proposed reprogramming of $41,000 from Health Maintenance Organizations to cover pay increase and bonus pay.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Payment to Hawaii (PHS Act, Section 331)

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$1,200,000	Indefinite	---	$1,200,000

Purpose: Payments are made to the State of Hawaii for care and treatment of persons with Hansen's disease.

Explanation: The appropriated funds are paid as a reimbursement of actual expense to the Department of Health of Hawaii to assist in care and treatment of Hansen's disease in its facilities. Any expenses above the appropriated funds are borne by the State of Hawaii.

Accomplishments in 1975: Care will be provided to an estimated daily average of 140 inpatients. This is a continuation of the decreasing inpatient load of recent years. Of the total program costs estimated to be $1,970,000, the share borne by Hawaii is $770,000.

Objectives for 1976: The average daily patient load is expected to be 134 in 1976. The total program requirements are estimated to be $2,156,000 of which the Federal government will pay $1,200,000.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Buildings and facilities

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
...	$1,300,000	Indefinite	...	...
Obligations				
...	$21,697,000		...	$3,729,000

Purpose: For construction, alterations, repairs and improvements of buildings and facilities, including preparation of plans and specifications.

Explanation: Funds appropriated are available until used for the purpose of this activity.

Accomplishments in 1975: Obligations are directed toward upgrading the PHS hospitals. In 1975, approximately $22 million will be obligated to support repair and improvement projects.

Objectives in 1976: In 1976 the PHS facilities will continue to be upgraded, utilizing funds available from prior year appropriations.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Emergency medical services (PHS Act, Title XII)

1975 Estimate		1976	1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$37,000,000	1/	---	$25,100,000

Purpose: The program of Emergency Medical Services has been designed to achieve implementation of self-supporting area-wide emergency medical services systems accessible to virtually all of the Nation's citizens.

Explanation: Grants and contracts are awarded to carry out the provisions of the Emergency Medical Services Systems Act of 1973, Title XII of the PHS Act. Grants and contracts provide financial assistance for (1) the conduct of feasibility studies and planning, (2) establishing and initial operation, (3) expansion and improvement, and (4) research projects for the development of area emergency medical services systems. Priority for funding is given to rural and other underserved areas.

Accomplishments in 1975: During 1975, an estimated 179 grant or contract awards will serve a potential population of 23,500,000 persons. The accompanying table indicates the number of grants or contracts to be awarded and financial assistance made available by specific sections of the Emergency Medical Services Systems Act. It is anticipated that the 1975 estimates will provide for the development of 29 new emergency medical services systems areas. Not less than 20 percent of the 1975 estimate, excluding research programs, will be made available to serve rural areas. Research programs in emergency medical techniques, methods, devices, and delivery will be continued.

Objectives for 1976: An additional 121 grants or contracts will be awarded for the development of an estimated 19 new emergency medical services systems areas that will serve an additional 9,500,000 persons. Priority will be given for the development of emergency medical services systems in rural areas. On a cumulative basis, the 1976 program will have provided for the development of 76 emergency medical service system areas and will serve a potential population of 38,000,000 persons. The following table indicates the estimated number of grants and contracts and available financing for the various sections of the Emergency Medical Services Systems Act.

Type of Grant or Contract	1975 No.	1975 Amount	1976 No.	1976 Amount
Feasibility studies and planning....	108	$4,875,000	75	$3,400,000
Establishing and initial operation..	27	19,500,000	19	13,600,000
Expansion and improvement.....	20	8,125,000	14	5,600,000
Research.....	24	4,500,000	13	2,500,000
Total	179	37,000,000	121	$25,100,000

1/ Legislative authority for the program expires June 30, 1976. Modifications are being proposed to extend the authorities of the Emergency Medical Services Systems Act. In addition, the proposal would delete the provisions which restrict funding for EMS initial operation grants.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Program management (PHS Act, Section 301)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
917	$32,517,000	Indefinite	907	$29,569,000

Purpose: This activity provides for the overall planning, direction, and administration of the Health Services Administration programs.

Explanation: This is a direct operating program which includes salaries and other operating funds to provide management support for the Health Services Administration's programs. The positions supported in this activity are utilized in headquarters to provide national leadership and direction to legislatively mandated programs, and in Regional Offices to provided grant administration and a full range of technical assistance and program guidance to present and potential communities and recipients of grants, contracts and loans.

Accomplishments in 1975: Community health centers program staff focused their attention on working with projects to enable them to improve their overall management capabilities. A priority emphasis has been on strengthening financial management. Third-party reimbursements levels increased from 17% of total operational costs in 1974 to 20% in 1975. Uniform performance criteria (program indicators) were developed and ambulatory health care standards were established and implemented in centers, helping them to achieve and maintain a higher level of quality services.

The major focus of the MCH program in F.Y. 1975 was the conversion from project to formula grants and the development of Programs of Projects as required by P.L. 93-53 in each of five categories (maternity and infant care, comprehensive care of children and youth, dental health of children, intensive infant care and family planning). Assistance has been provided to the States for this purpose. The development of third-party reimbursements from non-Federal sources has been a high priority.

In the family planning program initiatives were taken to improve project management and quality of care. Performance standards were introduced in order to monitor the quality of medical services, and the efficiency of project operations. New reporting requirements were added, and efforts have been focused on the collection of available reimbursements, particularly those authorized under Title IVA and XIX of the Social Security Act. In 1975, $9.1 million or approximately 6% of project cost was collected in third-party reimbursements.

The migrant health demonstration program was extended to six additional projects and nine hospitals. Program indicators and performance measures were developed to assist the program in identifying program management problems. With the use of these management techniques third-party collections increased to 8% of total operating costs.

The NHSC recruited 210 health professionals in 1975 and provided care to 600,000 people. F.Y. 1975 saw considerable refinement in the process of matching assignees to communities. Central office and Regional Office staff support and policy guidance has been provided for the operations of the PHS hospitals and clinics, Coast Guard medical program and Federal Employee Health program. Professional health personnel in the Emergency Medical Services program reviewed grant applications, made grant awards, and provided technical assistance and program guidance to grantees.

The Office of the Administrator provided policy guidance and evaluation of Agency progress in achieving its objectives to all programs with concentration on overseeing major new program initiatives. These included Health Maintenance Organizations, Professional Standards Review Organizations, Emergency Medical Service Systems, and emphasis on increasing third-party reimbursements.

Objectives for 1976:

A primary effort will be directed to the collection of third-party reimbursements, the expansion of community health centers delivery capability through increased productivity, improvement of the quality and scope of services offered, and the development and improvement of the management structure. The BCHS has defined seven issues in primary care development. They include the following activities: Funds allocation, data collection, quality of health care, third-party collection, System/model development, manpower management, and patient information and education. These issues are critical to the effectiveness of a primary care delivery system as supported by federal and non-federal funding sources.

Objectives of the Maternal and child health program in 1976 will include development of cost and utilization reporting requirements, implementation of a program for assisting states in analyzing maternal and child health needs for services, provisions of technical assistance to 56 political jurisdictions, development of specific criteria for evaluating the Program of Projects, development of policies for coordinating the activities of state Title V programs and local PSRO organizations, and development and dissemination of criteria for state plan development.

Activities of the family planning program will include the development of: a new reporting system and cost reporting requirements; educational materials for specific target groups; self-instructional materials for patients; a service integration initiative whereby family planning services will be integrated with other BCHS programs; and medical care guidelines and mechanisms for improving project performances.

The Migrant Health program will support the continued development of health services to serve migrants and seasonal farmworkers, implement a program to improve enviromental sanitation and implement a national record retrieval and referral system.

National health service corps staff will recruit and match health professionals, develop and approve 100 new NHSC sites, provide operational technical assistance to 220 sites conduct administrative support for 206 field sites and 405

assignees throughout the year.

The Bureau of Medical Services program management staff will continue to provide support to the Patient Care and Special Health Services programs as well as Emergency Medical Services and other Bureau of Medical Services programs. Professional health personnel will promote the development of emergency medical services systems; provide technical assistance to State and local communities in analyzing needs, review received proposals and issue notices of award for grants and contracts, monitor and evaluate projects.

The Office of the Administrator will plan, give direction and provide administrative support for a broad scope of programs and activities in the Health Services Administration. The Office of the Administrator will continue to formulate policies, regulations, program plans, and evaluate Agency programs in mission accomplishment. The Office of the Administrator will continue to structure, implement and oversee new program initiatives within the agency, such as: Health Maintenance Organizations, Emergency Medical Service Systems, Professional Standards Review Organizations, and Third-party reimbursements.

Payment to the General Services Administration for rent will continue to be provided.

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HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services[1/]

States	1974 Actual	1975 Continuing Resolution	1976 Request
Alabama	$1,676,000	$1,655,300	---
Alaska	400,400	402,400	---
American Samoa	265,700	265,700	---
Arizona	971,600	1,001,200	---
Arkansas	1,076,400	1,086,900	---
California	6,816,400	6,813,200	---
Colorado	1,090,300	1,102,200	---
Connecticut	1,248,400	1,243,400	---
Delaware	478,600	478,300	---
District of Columbia	514,400	513,100	---
Florida	2,803,000	2,882,900	---
Georgia	2,002,500	2,005,500	---
Guam	304,000	319,800	---
Hawaii	554,400	561,500	---
Idaho	580,000	578,800	---
Illinois	3,834,900	3,803,500	---
Indiana	2,102,100	2,091,100	---
Iowa	1,300,500	1,285,500	---
Kansas	1,053,600	1,059,800	---
Kentucky	1,545,000	1,542,500	---
Louisiana	1,716,700	1,713,600	---
Maine	683,500	681,800	---
Maryland	1,606,200	1,599,200	---
Massachusetts	2,156,400	2,162,200	---
Michigan	3,254,200	3,188,200	---
Minnesota	1,626,000	1,622,900	---
Mississippi	1,240,400	1,217,100	---
Missouri	1,936,600	1,915,900	---
Montana	557,600	553,400	---
Nebraska	818,700	819,700	---
Nevada	464,100	471,300	---
New Hampshire	569,900	569,900	---
New Jersey	2,606,500	2,576,700	---
New Mexico	701,900	713,700	---
New York	5,953,000	5,945,100	---

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services[1/] (Cont'd)

States	1974 Actual	1975 Continuing Resolution	1976 Request
North Carolina	$2,231,200	$2,207,600	---
North Dakota	529,400	533,100	---
Ohio	3,908,900	3,849,200	---
Oklahoma	1,261,600	1,263,600	---
Oregon	1,049,100	1,056,100	---
Pennsylvania	4,304,600	4,266,000	---
Puerto Rico	1,996,300	2,160,700	---
Rhode Island	625,200	623,100	---
South Carolina	1,334,300	1,334,300	---
South Dakota	550,200	550,500	---
Tennessee	1,823,000	1,820,100	---
Texas	4,427,700	4,458,500	---
Trust Territory	440,500	454,800	---
Utah	715,300	722,400	---
Vermont	465,000	470,100	---
Virgin Islands	265,700	265,700	---
Virginia	1,949,000	1,933,300	---
Washington	1,457,600	1,441,400	---
West Virginia	975,300	968,300	---
Wisconsin	1,861,900	1,859,000	---
Wyoming	418,300	418,900	---
Total	89,100,000	89,100,000	---
Evaluation Amount [2/]	900,000	900,000	---
Grand Total	90,000,000	90,000,000	

1/ Allocations are awarded to States based on population and per capita income with a minimum program requirement.

2/ Authorized by P.L. 91-296.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards[1/]
Fiscal Years 1974-6

States	1974[2/] Actual	1975 Enacted	1976 Request
Alabama	$1,220,100	$4,065,800	$3,562,100
Alaska	213,900	368,300	350,800
American Samoa	147,200	162,900	160,100
Arizona	416,252	1,383,700	1,337,600
Arkansas	724,000	2,287,200	2,002,100
California	3,156,700	10,268,300	8,039,100
Colorado	504,100	1,658,100	1,318,500
Connecticut	505,538	1,452,300	1,108,700
Delaware	288,000	578,300	461,000
District of Columbia	246,100	477,500	411,200
Florida	1,600,319	5,245,500	4,415,100
Georgia	1,836,400	5,423,400	4,865,600
Guam	168,400	264,400	242,200
Hawaii	252,600	686,600	443,200
Idaho	271,600	787,900	729,000
Illinois	1,779,600	5,817,300	4,782,200
Indiana	1,594,582	4,459,900	3,765,900
Iowa	794,094	2,435,900	1,984,400
Kansas	535,881	1,591,300	1,267,500
Kentucky	1,171,971	3,912,000	3,548,800
Louisiana	1,321,000	4,397,800	3,702,800
Maine	488,800	1,138,900	1,034,900
Maryland	1,086,700	3,606,400	2,865,100
Massachusetts	890,562	2,937,400	2,444,800
Michigan	2,007,100	6,627,200	5,267,700
Minnesota	949,150	3,111,700	2,479,000
Mississippi	1,472,628	3,479,200	2,992,800
Missouri	1,261,100	3,826,700	3,276,000
Montana	248,100	696,400	640,300
Nebraska	353,225	1,170,500	1,003,100
Nevada	210,548	347,100	324,900
New Hampshire	254,200	666,000	633,100
New Jersey	1,423,171	3,669,400	2,611,100
New Mexico	340,800	1,123,300	1,021,200
New York	2,669,500	8,712,300	7,703,300

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services (Cont'd)

Actual and Estimated Awards[1/]
Fiscal Years 1974-6

States	1974[2/] Actual	1975 Enacted	1976 Request
North Carolina	$2,524,231	$6,126,600	$5,438,500
North Dakota	312,900	668,300	482,800
Ohio	2,342,589	7,770,200	6,780,400
Oklahoma	778,300	2,064,300	1,887,400
Oregon	584,500	1,892,600	1,528,600
Pennsylvania	2,731,900	8,464,400	7,327,500
Puerto Rico	1,375,700	4,592,200	4,451,100
Rhode Island	254,100	547,400	425,500
South Carolina	1,293,600	3,780,500	3,403,900
South Dakota	259,600	734,100	627,000
Tennessee	1,443,551	4,096,900	3,486,300
Texas	2,958,300	8,732,400	7,735,600
Trust Territory	209,600	336,900	354,200
Utah	616,600	1,424,100	1,249,000
Vermont	266,500	561,100	520,000
Virgin Islands	158,200	247,800	195,400
Virginia	1,521,500	4,317,800	3,671,100
Washington	981,300	2,918,700	2,333,700
West Virginia	694,700	2,007,700	1,890,200
Wisconsin	1,331,600	3,496,400	2,966,200
Wyoming	211,500	330,200	297,900
Total distribution by formula 1/	55,254,692	163,947,500	139,847,500
Special projects for mentally retarded children	4,660,557	4,750,000	3,420,000
Other special projects	5,441,281	7,977,500	3,926,500
Total	65,356,530	176,675,000	147,194,000

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services (Cont'd)

Actual and Estimated Awards
Fiscal Years 1974-6

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Amounts awarded must be matched dollar for dollar.

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects is apportioned by formula. Each State receives an amount which varies directly with the number of urban and rural births in the State and inversely with State per capita income. No State receives less than $70,000 and rural live births are given twice the weight of urban births.

(c) The 1976 figures represent tentative apportionment of the amount requested.

2/ Amounts reflected in this column are actual obligations including non-recurring "B" funds released to some States after they received their notification of allocation of funds and Supplemental Funds made available under the Appropriation Act for the purpose of carrying out the provisions of P.L. 93-53 for the fiscal year ending 6/30/74.

HEALTH SERVICES ADMINISTRATION

Supplemental Allocations of Grants for Maternal and Child Health Services

Estimated Awards
Fiscal Years 1974-6

States	1974 Actual	1975 Enacted	1976 Request
Alabama	---	$202,836	---
Alaska	---	---	---
American Samoa	---	---	---
Arizona	---	166,259	---
Arkansas	---	---	---
California	---	---	---
Colorado	---	1,567,721	---
Connecticut	---	295,159	---
Delaware	---	---	---
District of Columbia	---	3,282,814	---
Florida	---	968,979	---
Georgia	---	---	---
Guam	---	---	---
Hawaii	---	327,257	---
Idaho	---	---	---
Illinois	---	2,930,725	---
Indiana	---	---	---
Iowa	---	---	---
Kansas	---	---	---
Kentucky	---	---	---
Louisiana	---	---	---
Maine	---	---	---
Maryland	---	2,299,237	---
Massachusetts	---	1,489,285	---
Michigan	---	480,528	---
Minnesota	---	---	---
Mississippi	---	---	---
Missouri	---	97,755	---
Montana	---	---	---
Nebraska	---	664,143	---
Nevada	---	57,030	---
New Hampshire	---	107,631	---
New Jersey	---	---	---
New Mexico	---	---	---
New York	---	7,379,303	---

HEALTH SERVICES ADMINISTRATION

Supplemental Allocations of Grants for Maternal and Child Health Services
(Cont'd)
Estimated Awards
Fiscal Years 1974-6

States	1974 Actual	1975 Enacted	1976 Request
North Carolina	---	---	---
North Dakota	---	---	---
Ohio	---	$239,138	---
Oklahoma	---	---	---
Oregon	---	---	---
Pennsylvania	---	---	---
Puerto Rico	---	1,845,834	---
Rhode Island	---	---	---
South Carolina	---	---	---
South Dakota	---	---	---
Tennessee	---	---	---
Texas	---	163,829	---
Trust Territory	---	---	---
Utah	---	---	---
Vermont	---	---	---
Virgin Islands	---	434,537	---
Virginia	---	---	---
Washington	---	---	---
West Virginia	---	---	---
Wisconsin	---	---	---
Wyoming	---	---	---
Total	---	$25,000,000	---

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services

Actual and Estimated Awards 1/
Fiscal Years 1974-6

State	1974 Actual 2/	1975 Enacted	1976 Request
Alabama	$1,366,800	$1,307,500	$895,600
Alaska	191,400	192,400	175,600
American Samoa	165,300	146,200	144,300
Arizona	526,600	496,600	364,200
Arkansas	844,700	763,400	543,400
California	2,809,200	2,844,900	2,081,200
Colorado	583,700	548,400	391,800
Connecticut	543,200	542,100	410,300
Delaware	229,400	219,100	194,600
District of Columbia	250,400	229,600	201,400
Florida	1,602,100	1,537,200	1,083,800
Georgia	1,656,500	1,596,500	1,124,600
Guam	164,400	155,100	150,600
Hawaii	265,192	254,200	218,000
Idaho	359,300	290,500	216,100
Illinois	1,784,600	1,872,600	1,333,200
Indiana	1,704,800	1,494,600	1,053,900
Iowa	1,118,900	889,300	613,100
Kansas	598,500	569,800	400,900
Kentucky	1,690,900	1,221,700	857,900
Louisiana	1,490,300	1,315,500	927,200
Maine	360,200	379,400	268,700
Maryland	845,800	861,100	599,100
Massachusetts	892,782	982,300	735,700
Michigan	1,990,100	2,120,900	1,455,000
Minnesota	1,154,600	1,102,800	766,700
Mississippi	1,128,200	1,072,600	733,600
Missouri	1,291,900	1,198,100	836,200
Montana	271,100	261,400	208,400
Nebraska	453,300	431,600	303,000
Nevada	262,879	213,100	191,000
New Hampshire	284,518	249,500	212,400
New Jersey	1,028,275	1,100,600	783,300
New Mexico	468,200	377,500	278,700
New York	2,465,600	2,594,400	1,924,800

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1974-6

States	1974 2/ Actual	1975 Enacted	1976 Request
North Carolina	$2,111,300	$2,033,300	$1,409,600
North Dakota	271,400	256,000	200,600
Ohio	2,451,679	2,516,700	1,771,600
Oklahoma	753,700	737,800	523,900
Oregon	627,900	587,500	422,400
Pennsylvania	2,681,600	2,814,400	1,963,200
Puerto Rico	1,570,400	1,484,300	1,122,500
Rhode Island	261,100	261,300	223,000
South Carolina	1,380,600	1,132,500	796,500
South Dakota	343,900	273,600	205,000
Tennessee	1,626,200	1,353,300	952,900
Texas	2,958,900	2,840,500	2,019,600
Trust Territory	147,729	160,000	154,000
Utah	346,300	341,100	267,600
Vermont	221,900	204,000	184,500
Virgin Islands	180,900	151,300	147,900
Virginia	1,493,000	1,402,500	960,400
Washington	972,800	812,600	569,000
West Virginia	852,400	740,000	510,900
Wisconsin	1,422,500	1,313,800	930,100
Wyoming	188,600	188,500	173,500
Total distribution by formula 1/	55,708,454	53,037,500	38,187,000
Special projects for mentally retarded children	4,995,374	5,000,000	3,600,000
Other special projects	6,356,982	6,862,500	4,941,000
Total	67,060,810	64,900,000	46,728,000

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of children under 21 years in the State. Amounts awarded must be matched dollar for dollar.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1974-6

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects, is apportioned by formula. Each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than a specific minimum amount and children in rural areas are given twice the weight of those in urban areas.

(c) The 1976 figures represent tentative apportionment of the amount requested.

2/ Amounts reflected in this column are actual obligations including non-recurring "B" funds released to some States after they received their notification of allocation of funds.

New Positions Requested

	Grade	1976 Number	1976 Annual Salary
Professional standards review organizations			
Public Health Program Specialist.....	GS-15	1	$29,818
Medical Care Administrator.....	GS-14	1	25,581
Nurse.....	GS-14	1	25,581
Public Health Program Specialist.....	GS-14	2	51,162
Public Health Program Specialist.....	GS-13	1	21,816
Medical Care Administrator.....	GS-13	1	21,816
Health Economist.....	GS-13	1	21,816
Public Health Program Specialist.....	GS-12	2	36,926
Public Health Program Specialist.....	GS-11	2	30,962
Clerical Assistant.....	GS-7	1	10,520
Secretary.....	GS-6	3	28,419
Clerical Assistant.....	GS-5	2	17,000
Total new positions.....		18	321,417
Bureau of Medical Services			
Occupational Health Nurse.....	GS-7	2	21,040
Total new positions, all activities		20	342,457

HEALTH SERVICES

For "Health services" for the period July 1, 1976, through September 30, 1976, $200,456,000: Provided, That not to exceed $6,521,000 may be transferred and expended as authorized by sections 201(g)(1) and 1168 of the Social Security Act, from any one or all of the trust funds referred to therein: Provided further, That any amounts received by the Secretary in connection with loans and loan guarantees under title XIII and any other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets, shall be available to the Secretary without fiscal year limitation for direct loans and loan guarantees, as authorized by said title XIII, in addition to funds specifically appropriated for that purpose: Provided further, That this appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses, hereafter incurred, by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health, Education, and Welfare, and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease from syphilis contracted from such person: Provided further, That when the Health Services Administration operates an employee health program for any Federal department or agency, payment for the estimated cost shall be made by way of reimbursement or in advance to this appropriation: Provided further, That $300,000 shall be available for payment to the State of Hawaii for care and treatment of persons afflicted with leprosy.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES ADMINISTRATION

Health Services

Amounts Available for Obligations 1/

	1976	Transition Period
Appropriation	$696,536,000	$200,456,000
Receipts and reimbursements from:		
"Federal funds"	19,991,000	4,996,000
"Trust funds"	24,671,000	6,521,000
"Non-Federal funds"	1,274,000	320,000
Unobligated balance, start of year	4,181,000	452,000
Unobligated balance, end of year	-452,000	---
Total, obligations	746,201,000	212,745,000

1/ Excludes the following amounts for reimbursable activities carried out by other accounts: 1976 estimate $6,461,000; transition period estimate $1,615,000.

Obligations by Activity*

Page Ref.		1976 Estimate Pos.	1976 Estimate Amount	1976 Transition Estimate Pos.	1976 Transition Estimate Amount
	Community health services:				
117	(a) Community health centers.....	---	$155,190,000	---	$48,000,000
117	(b) Maternal and child health:				
117	(1) Grants to States.....	---	193,922,000	---	62,600,000
117	(2) Research and training....	---	17,500,000	---	14,909,000
	Subtotal.....	---	211,422,000	---	77,509,000
117	(c) Family planning.....	---	79,435,000	---	7,000,000
117	(d) Migrant health.....	---	19,200,000	---	3,500,000
117	(e) Health Maintenance organizations:				
117	(1) Grants and contracts.....	---	15,000,000	---	4,043,000
117	(2) Program support.....	125	3,612,000	125	957,000
117	(3) Loan & Loan guarantee....	---	---	---	---
	Subtotal.....	125	18,612,000	125	5,000,000
118	(f) National health service corps.....	405	12,529,000	405	5,300,000
	Subtotal.....	530	496,388,000	530	146,309,000
	Quality assurance:				
118	(a) Medical care standards.....	167	4,537,000	167	1,264,000
118	(b) Professional standards review organizations.....	173	50,145,000 (30,011,000)	173	13,011,000 (7,754,000)
	Subtotal, obligations....	340	54,682,000 (30,011,000)	340	14,275,000 (7,754,000)
	Patient care and special health services:				
118	(a) Patient care.....	4,801	120,333,000 (105,164,000)	4,801	33,374,000 (29,582,000)
118	(b) Coast Guard medical services.	151	8,498,000	151	2,376,000
118	(c) Federal employee health.....	267	6,702,000 (606,000)	267	1,686,000 (162,000)
119	(d) Payment to Hawaii.....	---	1,200,000	---	300,000
	Subtotal, obligations....	5,219	136,733,000 (115,468,000)	5,219	37,736,000 (32,420,000)
119	Buildings and facilities.....	---	3,729,000 (---)	---	452,000 (---)
119	Emergency medical services.....	---	25,100,000	---	6,275,000
119	Program management.....	907	29,569,000	907	7,698,000
	Total obligations.....	6,996	746,201,000 (696,536,000)	6,996	212,745,000 (200,456,000)

* Where budget authority differs from obligations, budget authority is shown in parentheses.

Obligations by Object

	1976 Estimate	Transition Period Estimate
Total number of permanent positions	6,996	6,996
Full-time equivalent of all other positions	425	425
Average number of all employees	7,232	7,232
Personnel compensation:		
Permanent positions	$97,467,000	$25,949,000
Positions other than permanent	4,896,000	1,311,000
Other personnel compensation	6,542,000	1,758,000
Special personal services payments	375,000	102,000
Subtotal, personnel compensation	109,280,000	29,120,000
Personnel benefits	21,044,000	8,145,000
Benefits for former personnel	400,000	109,000
Travel and transportation of persons	4,031,000	1,124,000
Transportation of things	1,354,000	360,000
Rent, communications, and utilities	8,144,000	2,109,000
Printing and reproduction	575,000	148,000
Other services	29,957,000	7,642,000
Project contracts	52,182,000	13,443,000
Supplies and materials	13,803,000	3,719,000
Equipment	2,567,000	585,000
Lands and structures	1,417,000	222,000
Grants, subsidies and contributions	500,747,000	146,069,000
Subtotal	746,401,000	212,795,000
Deduct quarters and subsistence charges (-)	-200,000	-50,000
Total obligations by object	746,201,000	212,745,000

Justification

Community health centers $48,000,000

An estimate of $48,000,000 is requested for the period July 1, 1976 - September 30, 1976. This amount exceeds the one-quarter distribution of the 1976 estimate by $9,203,000, due to the large number of project grants that require funding during this three month period. Fifty-two community health centers will receive Federal funds to support ambulatory health care service programs.

Maternal and child health - Grants to States $62,600,000

An estimate of $62,600,000 is requested for the period July 1, 1976 - September 30, 1976. This amount exceeds the one-quarter distribution of the 1976 estimate by $14,119,000, due to the large number of project grants that require funding during this three month period. Estimates are based on the funding of 151 project grants and the distribution to the States of formula grant funds.

Maternal and child health - Research and training $14,909,000

An estimate of $14,909,000 is requested for the period July 1, 1976 - September 30, 1976. This amount exceeds the one-quarter distribution of the 1976 estimate by $10,534,000, due to the large number of research and training projects that require funding during this three month period. Estimates are based on the funding of 8 research and 26 training projects.

Family planning $7,000,000

An estimate of $7,000,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was based on continuing to fund 16 ongoing family planning grants.

Migrant health $3,500,000

An estimate of $3,500,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was based on continuing to fund 16 projects.

Health maintenance organizations $5,000,000

An estimate of $5,000,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was based on providing funds to 5 developmental projects totaling $4,043,000 and $957,000 for program support computed on the basis of 25 percent of the 1976 President's Budget request plus mandatory cost increases of $52,000 for within grade and longevity costs and $2,000 for one extra day of pay.

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National health service corps $5,300,000

An estimate of $5,300,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate exceeds 25 percent of the 1976 President's Budget request by $2,168,000 due to the large number of physicians eligible for commissioned officers' bonus pay.

Medical care standards $1,264,000

An estimate of $1,264,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request plus mandatories. The estimate exceeds the 25 percent distribution by $112,000 to meet commissioned officers' bonus pay requirements.

Professional standards review organizations $13,011,000

An estimate of $13,011,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was based on 25 percent of the 1976 President's Budget request plus mandatories. This estimate exceeds the 25 percent distribution by $75,000 to meet commissioned officers' bonus pay requirements and $330,000 for anticipated contracts which will need refunding.

Patient care $33,374,000

An estimate of $33,374,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request plus $2,009,000 for commissioned officers' bonus pay, $682,000 for increases in contract medical care, $411,000 within grade and longevity increases, $61,000 for one extra day of pay, $8,000 for FICA charges, and $120,000 for changes in rates such as utilities and postage.

Coast Guard medical services $2,376,000

An estimate of $2,376,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request plus $202,000 for commissioned officers' bonus pay; $46,000 for increases in contract medical care; $3,000 for within grade, longevity increases, and increases in FICA charges.

Federal employee health $1,686,000

An estimate of $1,686,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request plus $9,000 for commissioned officers' bonus pay and $2,000 for within grade increases.

Payment to Hawaii $300,000

An estimate of $300,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request.

Buildings and facilities $452,000

An estimate of $452,000 is requested for the period July 1, 1976 - September 30, 1976. This provides for the Public Health Services facilities to continue to be upgraded using funds appropriated in prior years. No new funds are being requested.

Emergency medical services $6,275,000

An estimate of $6,275,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request. Thirty grants and contracts will receive Federal funds.

Program management $7,698,000

An estimate of $7,698,000 is requested for the period July 1, 1976 - September 30, 1976. This estimate was computed on the basis of 25 percent of the 1976 President's Budget request plus mandatory cost increases such as $174,000 for commissioned officers' bonus pay, $108,000 for within grade and longevity increases, and $22,000 for one extra day of pay.

CENTER FOR DISEASE CONTROL

PREVENTIVE HEALTH SERVICES

WITNESSES

DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL
EDWARD J. BAIER, ACTING DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH
JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL
CLAUDE F. PICKELSIMER, DIRECTOR, FINANCIAL MANAGEMENT OFFICE, CENTER FOR DISEASE CONTROL
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLOOD. The hearing will come to order.

We are meeting on the Center for Disease Control of the U.S. Public Health Service.

The presentation will be made by Dr. David J. Sencer, Director of the Center for Disease Control.

Dr. Sencer is well known to us, having been here before. We have a biographical sketch of you, Doctor, which we will place in the record at this point.

[The information follows:]

BIOGRAPHICAL SKETCH OF DAVID J. SENCER, M.D.

Position: Director, Center for Disease Control.

Birthplace and date: Grand Rapids, Mich., November 10, 1924.

Education: Wesleyan University, Middletown, Conn., 1944; University of Mississippi, 1946; University of Michigan, 1951, M.D.; University Hospital, Ann Arbor, Mich., 1951, Intership Internal Medicine Residency, 1954; and Harvard University School of Public Health, 1958, M.P.H.

Experience: 1966-Present, Director, Center for Disease Control, Atlanta, Ga.; January 1973–May 1973, Acting Administrator, Health Services and Mental Health Administration; 1964–66, Deputy Chief, Center for Disease Control, Atlanta, Ga.; 1960–64, Assistant Chief, Communicable Disease Center, U.S. Public Health Service, Atlanta, Ga.; 1959–60, Program Officer, Bureau of State Services, U.S. Public Health Service, Washington, D.C.; 1955–59, Medical Officer in Charge, Muscogee County TB Field Research Facility, DSPBS, Columbus, Ga.; and 1955, Medical Consultant, Tuberculosis Program, U.S. Public Health Service.

Teaching appointments: Visiting Lecturer on Tropical Public Health, Harvard University School of Public Health, Boston, Mass.; Clinical Professor of Preventive Medicine, Emory University School of Medicine, Atlanta, Ga.

Association memberships: American Medical Association; American Public Health Association; American Thoracic Society; American Society of Tropical Medicine and Hygiene; Delta Omega; Georgia Tuberculosis Association; International Epidemiological Association; Diplomate, American Board of Preventive Medicine; Fellow, American College of Preventive Medicine; and Board of Governors of the United States-Israel Binational Science Foundation.

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Sencer, David J., Dull, H. Bruce and Langmuir Alexander D.: Epidemiologic basis for eradication of measles in 1967. A Statement by the Public Health Service. Public Health Rep. 82:253–256, 1967.

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Mosley, J. W. and Sencer, D. J.: Isoniazid toxicity. JAMA 218:447, 1971.

Sencer, David J., and Rubin, Robert J.: Risk as the basis for immunization policy in the United States. Prepared for delivery at Symposium on Influenza Vaccines for Men and Horses, November 1972, London, England. Symp. Series Immunobiol. Standard. Vol. 20. Basel/New York, Karger, 1973, pp. 244–251.

Mr. FLOOD. Do you have some people you would like to introduce to us?

Dr. SENCER. Yes; we have Mr. Ed Baier, Acting Director, NIOSH; James D. Bloom, Executive Officer; Claude F. Pickelsimer, Director, Financial Management Office, and Charles Miller, Deputy Assistant Secretary, Comptroller.

Mr. FLOOD. We have your prepared statement.

[The information follows:]

STATEMENT OF DR. DAVID J. SENCER, DIRECTOR

Mr. Chairman, members of the committee, it is a pleasure to present the budget for Preventive Health Services for fiscal year 1976. Rather than catalog all of the activities that are carried out under this appropriation, I would like to highlight three areas: (1) accomplishments in infectious disease control, (2) health problems of workers, and (3) progress in clinical laboratory improvement.

ACCOMPLISHMENTS IN INFECTIOUS DISEASE CONTROL

Monday, April 7, was World Health Day. The subject was smallpox. This will be a historic year in medical history. For the first time, man will have knowingly eradicated a disease. Epidemics of this disease have changed history. Millions have suffered from it in the past. This disfigurement and pain of the disease is matched by the number of people it kills. In some societies, parents have not counted a child as one of theirs until he has survived smallpox. In 1966, the World Health Organization and its 123 members agreed to undertake a worldwide eradication program. The United States has been an active participant. While this appropriation has not directly supported this country's efforts, hundreds of our employees have lived and worked in the cooperative program to conquer this disease. In 1966, smallpox was epidemic in 29 countries. Today, smallpox can be found in only three—India, Bangladesh, and Ethiopia. We anticipate that India will be free of the disease within the next few weeks. By the end of the year the other two countries shall also have seen the last case of smallpox.

To fully understand the magnitude of this accomplishment, you must realize that these problems have been in countries with the most limited resources. We have had to overcome the difficult barriers of communication, transportation, and

education. It is not just those countries where smallpox was epidemic that have benefited. Our country has also benefited. As a result of the amazing success of the smallpox eradication program, the United States has been able to readjust its immunization policy so that no longer is it necessary that all children be routinely vaccinated. Since 1971, we estimate that it has been unnecessary to vaccinate more than 6 million children alone, saving conservatively in excess of $54 million in office visits. While we can be proud of the accomplishments in smallpox eradication, we must not forget that infectious disease problems are still the major health problem of most of the world. Malaria is resurgent and parasitic and diarrheal diseases are still a major limitation to progress in most of the developing countries of the world.

Domestically, we also witnessed major accomplishments in disease control. Last year there were only five cases of poliomyelitis in the entire United States—the lowest number ever. By comparison, in 1954, the year before the introduction of poliomyelitis vaccine, there were 18,308 cases. Most of us in this room remember the near panic that a polio outbreak would cause. Swimming pools would be closed, movies would be closed, parents would keep their children home.

Today we count on one hand the number of cases of paralytic polio in the United States. Measles is also at an all-time low, as are rubella and diphtheria, diseases for which we have good immunizing agents. The Public Health Service does not take credit for all these accomplishments. It was only through the combined efforts of the private and public sector and voluntary agencies that this rapid change in the pattern of disease in this country was brought about. But having a national initiative has helped the United States to more rapidly control these diseases. Our program for measles immunization had a national focus, national publicity, and national enthusiasm tied in with private medicine, private industry, and public health agencies. The decline in measles was precipitous in this country, dropping from 204,136 cases in 1966 to 22,231 cases in 1968. This can be compared with a country in which measles vaccination was not made a focus of national attention, but was an allowable procedure in the National Health Service. The decline of measles in that instance was from 343,642 in 1966 to 233,887 in 1968.

We cannot, however, allow our past success or the absence of a disease to minimize control efforts. If we do, and the disease-causing agent is still with us, the disease will come back to afflict us. To assure that high levels of immunity against these diseases are maintained, we have organized immunization action month—a coalition of the American Medical Association, the American Academy of Pediatrics, State and Territorial Health Officers, the pharmaceutical industry, and many other voluntary agencies. All these organizations coordinate efforts during the month of October to alert parents as well as physicians and school authorities of the need to protect all children against measles. We have indications that this program contributed to improved levels of immunization between 1973 and 1974.

Progress has been made in controlling sexually transmitted diseases. The rate of increase in gonorrhea continue to diminish, dropping from a 12.7 percent increase in fiscal 1973 to 8 percent in fiscal 1974 and to only 4.8 percent in the first half of 1975. We do have problems in syphilis control with slight increases in infectious syphilis. However, these increases are localized and concentrated in the male population. This has served to focus our attention on a problem that we have known about for many years, that is, transmission of syphilis in the male homosexual population. This is not generalized throughout the homosexual community, but localized in those members who have difficulty in gaining access to health care services. We are working with homosexual groups in efforts to provide more effective services to this population which should help to control this previously hidden problem.

You will note that I began this section of my statement as referring to the sexually transmitted disease rather than venereal disease. Venereal disease, in the past, has been traditionally syphilis and gonorrhea and the three minor venereal diseases. Today, however, two other sexually transmitted diseases are being seen with increasing frequency in venereal disease clinics. These are genital herpes, a viral disease that is not only an acutely painful disease, but also a major contributor to mental retardation in babies who are exposed during the fetal period. Also, there is increasing evidence that the herpes virus is associated with cancer of the cervix. The other problem is that of nonspecific urethritis which we now believe is caused by one of the mycoplasma and resembles gonorrhea in its most common clinical manifestation. Therefore, in orga-

nizing venereal disease control programs, we are increasingly taking into account the other sexually transmitted diseases and offering comprehensive service in the venereal disease clinics that are supported by these funds.

While not an infectious disease, the techniques that we have used in controlling the infectious diseases, namely the identification of high risk populations, screening and bringing to treatment and correcting the causes are used in controlling and preventing lead-based paint poisoning. This program began in 1972 and since then 825,000 children at high risk have been screened. Almost 70,000 of these had elevated blood lead and one-tenth of those had a blood level high enough that therapy has been necessary. It is not enough to screen and then send the children back to the same environment. In this same period of time, lead hazard reduction has been accomplished in approximately 24,000 dwelling units. I would hasten to add, Mr. Chairman, that this hazard reduction has been done with local resources and with less than $150,000 in Federal funds expended.

In support of these and other activities supported by project grants, we are requesting a $19,788,000 decrease over the 1975 estimate. The reduction in project grants is predicated on the fact that the Federal Government has been supporting these activities for a considerable time and there is a need for increased State and local contribution as was discussed in Dr. Cooper's opening statement. The decrease of $916,000 in the direct operations for disease control results from the change in policy which will require State and local public health agencies to reimburse the Federal Government for the training they receive.

HEALTH OF WORKERS

The known and estimated cost of occupational diseases and injuries are the basis for the preventive activities of the National Institute for Occupational Safety and Health. Occupational factors, although not adequately quantified, play a far more significant role in the causation of major diseases and injuries in the United States than is presently realized. We have, in the past, estimated that over 100,000 premature deaths occur annually due to occupational insult exposures. More scientific evidence is required before this figure can be substantiated. However, recent information from the National Institutes of Health indicates that 70 to 80 percent of all cancers are environmentally caused; research in the United Kingdom indicates that over 80 percent of cancers are of environmental origin. Examples, such as the recent disclosures relating to vinylchloride, may be a prelude to the quantification of the occupational portion of this disease. In a worker population of 5,600 men employed at 36 facilities in the United States producing polyvinylchloride, 15 cases of a very rare cancer of the liver have been reported from four of these plants. We would have expected an incidence rate for the entire United States of only 20–25 cases of this rare cancer in any year. Most of the workers in whom the disease was found had been employed over 20 years ago. The length of time required for the disease to evidence itself is the very reason it has been difficult to totally determine the extent and seriousness of the occupational disease problem. Similar episodes can be related for arsenic, asbestos, chloroprene, bis (chloromethyl) ether, and many other occupational insults.

Another example of an unusual disease causing occupational exposure in the recent episode of loss of muscle control in the extremities in workers exposed to methyl butyl ketone. This response, called peripheral neuropathy, has been reduced through interim control practices established in the workplace based on examination of employees in 9 plants and industrial hygiene evaluations at 12 plants.

While NIOSH has initially focused much of its energy and resources on the problems of occupational diseases, we have taken steps to prioritize problems related to occupational injuries and to undertake the necessary research to support criteria for recommending safety standards to the Department of Labor. For example, we know that the accidental death rate for structural steel workers, boilermakers, and lumbermen, is twice the rate for the general population. Presently, we have undertaken a program of activities that will provide the logging industry with recommendations for work practices that should significantly reduce the number of deaths and the number and severity of injuries.

Without considering the obvious elements of human suffering associated directly and indirectly with injury and death on the job, we know the economic costs are staggering. For example, the average employee is absent from work roughly 6 days per year. It has been estimated that if only one of the 6 days was recov-

ered for productive purposes because preventive measures had been instituted in the workplace, $10 billion would be added to the gross national product.

We have an enormous job ahead of us—next year and for many years to come. Our immediate concern is to get an expanded program underway in research on occupational carcinogenesis. This emphasis is reflected in our budget request. With some changing of priorities and a modest increase in funds, we will be able to meet rising mandatory costs and launch into an expansion of our carcinogen research that will cost nearly $1.3 million.

PROGRESS IN LABORATORY IMPROVEMENTS

In 1966, this committee requested the Public Health Service to prepare a report on problems that were encountered in clinical laboratories in the United States. There are 14,000 such laboratories in the United States, 7,000 of them based in hospitals. The volume of laboratory service is not accurately known, but it is estimated that $12 billion (or 15.5 percent) of expenditures for health services in this country are for laboratory services. In our 1966 report to this committee, we document problems in clinical laboratories. Few of these deficiencies were willful. In 1966, there were no uniform standards of laboratory performance and there was no uniform enforcement of the standards that were available. As a result of the report to the committee, the Clinical Laboratory Improvement Act was passed. We believe significant progress has been made in carrying out this new law. Eight hundred and seventy laboratories are now participating in programs that have uniformly high standards. More than 70 laboratories, including the largest in the country, are now licensed by the Federal Government. Another 150 laboratories are accredited under an inspection and accreditation program the Federal Government enforces. We are entering into an agreement with the Social Security Administration so that these uniform quality control standards will be in effect for social security medicare certified laboratories. We recognize that merely having standards does not assure that they are followed. Therefore, we are working with the Social Security Administration to develop a training program so that inspectors for medicare laboratories use the same standards of inspection as those we use for interstate commerce laboratories.

However, laboratory improvement is not merely setting and enforcing standards. There is also a need to identify problem areas and take corrective action. This is done, not just by the inspection process, but also by proficiency testing programs. Such programs tell us if we have a problem with laboratory methods, the agents that are used for testing, or the individual laboratory performing the test. CDC also provides short-term training to personnel to upgrade procedures. Since inception of the act, short-term bench training has been provided to more than 900 laboratorians. We are working cooperatively with the Food and Drug Administration to develop standards for diagnostic materials (reagents), because no matter how good the people and how good the methods, if we don't have good materials the tests can be erroneous. Finally, we conduct research to develop better methods of laboratory diagnosis, not just for infectious diseases, but also for chronic conditions.

Mr. Chairman, I will be happy to answer any question that you or other members of the committee may have.

SYPHILIS

Mr. FLOOD. Last year you told us that you are hoping for a 5-percent reduction in the infectious syphilis area in fiscal 1975. Are you going to achieve that goal?

Dr. SENCER. No, sir, we are not. Actually infectious syphilis will be up slightly in this fiscal year. This is mainly in two different parts of the country, Florida and California.

Mr. FLOOD. Suppose I put this in, too, at that point. The budget justification now indicates that there is a trend that infectious syphilis has stabilized. Does that mean that you have exhausted all your efforts to reduce the incidence of the disease?

Dr. SENCER. No. It is now decreasing in all parts of the country except Florida and California. The rates this year would be lower than last year, except for the increases we have seen in those two States.

Mr. FLOOD. I suppose you do not want me to ask you why those two States, do you?

Dr. SENCER. It gets into a problem we mentioned in our opening statement, Mr. Chairman. The increases in infectious syphilis are principally in men. The rates in women are going down. Epidemiologic evidence would lead us to believe that this is occurring in certain segments of the male homosexual population. This is not a solely homosexual problem, nor is it all homosexuals.

GONORRHEA

Mr. FLOOD. In your justification you state that gonorrhea ranks first among all of the reportable diseases and that there was a 12.7 percent increase in the instance of gonorrhea in 1974. Well, now, that is what you tell us. Given these facts, we do not understand this proposed reduction here of $5,358,000 in VD project grants.

Can you explain how you are going to continue to attack this problem when you have 28 percent fewer resources?

Dr. SENCER. Actually this is part of the overall strategy of the Department to encourage greater State and local participation in the health services delivery programs. The rate of increase in gonorrhea in the last fiscal year was down from the previous one. It was only a 4.8-percent increase in the first half of the current fiscal year. We are continuing to make progress. We feel there is a need for increased State and local participation.

Mr. FLOOD. And this is the way you are going to get it, you are going to twist their arms?

Dr. SENCER. Yes.

The plan is that regulations will be promulgated that would require 20-percent participation.

Mr. FLOOD. If they do not do it, up goes the gonorrhea rate and you will say that is their fault.

Dr. SENCER. We hope to be able to find the resources to prevent that.

Mr. FLOOD. Where?

Dr. SENCER. We are working with other delivery systems.

Mr. FLOOD. Federal?

Dr. SENCER. Federal, medicaid in particular, in terms of trying to build screening in their teenage program in the early and periodic screening, diagnosis, and treatment program.

Mr. FLOOD. Are you talking about revenue sharing, too?

Dr. SENCER. I was not talking about that.

Mr. FLOOD. You do not think they will use these funds for gonorrhea prevention, do you?

Dr. SENCER. That is one of their big problems.

Mr. FLOOD. Do you think they will use revenue sharing funds for health services?

What percentage do you think they will use?

Dr. SENCER. I couldn't guess.

Mr. FLOOD. Would you be surprised if it was not over 3 to 5 percent?

Dr. SENCER. I would not be surprised.

Mr. FLOOD. Well, that is what it is.

Still talking about gonorrhea, will that cutback reduce the mass screening programs for women?

Dr. SENCER. Yes, sir.

The plans are, with this cutback, to look at those mass screening areas that have been least productive. Some of the programs in private physicians' offices that we have been supporting have been less productive. We know we can concentrate on screening between the ages of 15 and 25 still get the most productivity.

VENEREAL DISEASE EDUCATION

Mr. FLOOD. You have been telling us that a very important part of the VD program has been the educational activities. What impact will the reduction in funds have on this segment of your program?

Dr. SENCER. We have two ways in which venereal disease education is carried out. One is through the project grants where State and local agencies develop programs targeted for their particular circumstances. On a national basis we are working with the Junior Chamber of Commerce.

Mr. FLOOD. I know about that.

Dr. SENCER. That particular work will not be affected by this budget cut.

IMMUNIZATION

Mr. FLOOD. Again in your budget justifications you state that fewer cases of polio, measles, and rubella were reported in 1974 than any year at all since the reporting of diseases, since it began. I certainly think that your staff deserves to be commended in that area.

Can you sustain that trend with the funds available in the budget for these immunization activities? You have a 21-percent decrease. How will you do that?

Dr. SENCER. Here again we would try to work with the State and local communities to take advantage of other mechanisms of getting funds for early and periodic childhood screening, diagnosis and treatment, third party reimbursements where they are available and again, encourage local resources to help make up the gap.

Mr. FLOOD. Of course I don't blame you. You are sitting there and you are the witness. I'm asking the questions. Knowing you like I do, I just don't feel your heart is in it. I have seen you sit there for years and come out punching for God, country and Yale. I don't see that right now. Is medicaid going to assist you in maintaining the current immunization levels?

Dr. SENCER. In some States.

It is really 50 different programs. We have been successful in several instances in getting substantial commitments of medicaid money to assist in the immunization programs.

RAT CONTROL

Mr. FLOOD. This budget practically eliminates the rat control program. I thought the idea of this program was for the Federal Government to initiate a project and for the local governments to take over the operation of that project after 3 or 4 years.

What has been your experience so far with local governments?

Dr. SENCER. In rat control it has been surprisingly good. Almost 50 percent of the expenditures in the urban rat control programs are from local resources.

Mr. FLOOD. I hope you are still against rats.

Dr. SENCER. Yes.

I think we have to look at this as a health budget. In setting priorities for health, rats are not a particularly severe health problem. They are a social, economic, and housing problem. We feel if we are going to have to establish our priorities for health, rats should take a lower priority.

Mr. FLOOD. Then you have a realinement of priorities. Anyhow, are you going to be able to meet your commitments to the existing projects under this budget?

Dr. SENCER. No, sir.

We are going to have to reduce commitments in fiscal 1976 and perhaps discontinue some projects.

Mr. FLOOD. In your budget justification you state, "As a result of these ongoing projects, they are reaching a maintenance level" and you say that you will be able to assist other cities who have a critical need for this rat control program. How many other cities are you going to do that for in this budget?

Dr. SENCER. As Dr. Cooper said yesterday, because of the premises upon which this budget was based, taking into account rescissions, we are not in a position to tell you which cities or communities we will discontinue or change at this time.

Mr. FLOOD. Are you going to be able to do that before this record is printed? Will you try to get something?

Dr. SENCER. We can try, yes, sir.

Mr. FLOOD. We have to have some kind of an answer to that question. We cannot say we are going to do this and then blank.

Dr. SENCER. We will supply the information for the record.

[The information follows:]

CITIES OR COMMUNITIES THAT HAVE A CRITICAL NEED FOR RAT CONTROL PROGRAMS THAT WILL BE ASSISTED BY CDC

Although funding decisions have not been finalized, we expect applications from the following areas which have a critical need: Hartford, Conn.; the Tremont Park section of New York City; Ponce, Puerto Rico; Boston, Mass.; Omaha, Nebr.; and several cities in Florida, particularly Tampa and Jacksonville.

LEAD BASED PAINT POISONING

Mr. FLOOD. Now with regard to the lead based poisoning program, this is something you have been pounding the table about for years. Do all 50 States have the capability of performing the blood lead analysis?

Dr. SENCER. Not all of them, but the bulk of the population in the country live in States where there are screening programs available.

Mr. FLOOD. What do you mean by "bulk"?

Dr. SENCER. I will provide that for the record.

Mr. FLOOD. You say the bulk now, but detail it for the record, please.

Dr. SENCER. Yes, sir.

[The information follows:]

LIST OF STATES THAT HAVE THE CAPABILITY OF PERFORMING BLOOD-LEAD ANALYSIS

Alabama, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Puerto Rico, South Carolina, Texas, Virginia, Wisconsin and Wyoming.

Mr. FLOOD. Last year this committee directed the Center for Disease Control to take the initiative to assist the other service programs in the Department to incorporate routine lead poison screening into their programs. What sort of assistance did you provide for these programs and what was the result of your effort?

Dr. SENCER. We have worked it so the lead screening has been recommended to medicaid as a necessity. We have developed the methodology for medicaid to use in their programs. We have worked with neighborhood health centers to assure that when they are screening children they not try to do the lead determinations but submit them to the State centers.

Mr. FLOOD. What was the result of your efforts?

Dr. SENCER. We feel we are going to reach more children this year than we have in any other year.

About 500,000 children will be screened in this fiscal year as against a total of $865,000 in the preceding 3 fiscal years.

Mr. FLOOD. We have the impression that your assistance was minimal with very little results.

What do you think about that?

Dr. SENCER. I do not think it is because we have not tried.

Mr. FLOOD. I agree with that. But that restates the question.

Dr. SENCER. We can provide the technical assistance to other agencies but we cannot be responsible for what is or is not done.

Mr. FLOOD. We have a vicious circle, apparently.

It is funny what happens to these hearings the next year or 2 years later. You would think we were talking about a different ball game.

Will you be able to screen the same number of children in 1976 for lead poisoning as you were in 1975?

Dr. SENCER. Yes; we think we will be able to screen approximately the same number because in this year we have been able to adapt a method of screening that is less expensive.

Mr. FLOOD. Have any of the States initiated their own lead poisoning screening program?

Dr. SENCER. I cannot tell you whether they have an identifiable program but I do know that 28 of the States do have the capability in their State public health labs to do it.

Mr. FLOOD. I know that. But I ask you flatly, are there any States who have initiated their own?

Dr. SENCER. Not without Federal assistance, no, sir.

LABORATORY IMPROVEMENT

Mr. FLOOD. In your justification you state that in fiscal year 1975, 1,100 clinical labs were evaluated and only 882 were found to meet the standards.

Does that mean a physician who depends upon the labs that did not meet the standards for his diagnostic results will get incorrect data?

Dr. SENCER. In many instances he will get data that will be inaccurate.

We feel that our standards are high and he would not necessarily be getting extremely dangerous data, but we do feel all of this could be improved.

Mr. FLOOD. What has happened to the 218 labs that did not meet the standards?

Dr. SENCER. A few of them were not licensed because they did not meet the standards. In other instances licenses were revoked.

Mr. FLOOD. Who revokes the license?

Dr. SENCER. We do.

Mr. FLOOD. In a few instances?

Dr. SENCER. Yes.

Mr. FLOOD. Why not revoke them all?

Dr. SENCER. Because we can provide technical assistance so they can provide good service.

Mr. FLOOD. You are cutting out 40 jobs from the staff. This is the lab improvement program. You are cutting 40 jobs out of the staff. How do you add that up?

Dr. SENCER. We are not actually cutting out 40 jobs because these jobs were never filled.

Mr. FLOOD. You are cutting 6 inches from the bottom of the blanket and putting it on top because the blanket was not long enough.

How many States have the laboratory program?

Dr. SENCER. All States have a lab inspection program with medicare. We have one State that has a laboratory program that has been recognized by the Secretary to be as effective as ours.

There are about eight other States that we feel have excellent programs.

Mr. FLOOD. I want you to list them. Everybody says, "What about mine?" So get them in there.

[The information follows:]

LABORATORY IMPROVEMENT

Those States having excellent laboratory programs are New York, Pennsylvania, Maryland, Florida, Wisconsin, Utah, California, and Connecticut.

HEALTH EDUCATION

Mr. FLOOD. Last year you said you were undertaking a new initiative to provide leadership and coordination of all the health education activities across the whole range of private sector programs. What do you find 1 year later in that operation?

Dr. SENCER. We think we have made considerable advances in this area. We will be getting a report from the National Health Council in May. One of our big initiatives was to determine whether it was feasible to set up a health education institute outside of Government. We should be getting that report in May on schedule.

We have had meetings with all the State health departments and health educators from each State health agency to determine what their priorities are and what we can do to provide assistance to them.

Mr. FLOOD. Can you tell us the number of Federal programs involved

in this whole thing of consumer health education and how much money is involved?

Dr. SENCER. Yes. We have a catalog of those programs authorized to be in health education. We have an estimate which was made 2 years ago that about $50 million is going into health education in various programs in HEW.

Mr. FLOOD. Is that too complicated to place in the record?

Dr. SENCER. No, sir, we can do that.

Mr. FLOOD. All right, suppose you do that.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PROGRAM AUTHORITIES FOR HEALTH EDUCATION

I. PUBLIC HEALTH SERVICE

A. CDC

1. Public Law 91-222, Public Health Cigarette Smoking Act of 1969 (15 U.S.C. 1331-1339).

2. Public Law 78-410: (*a*), Lead-based Paint (sec. 101(c)(1) (42 U.S.C. 4801)); (*b*), General (sec. 301(a) (42 U.S.C. 241)); (*c*), Health conditions (sec. 315); (*d*), Immunizations (sec. 317(2)(B) (42 U.S.C. 247b)); and (*e*), Venereal disease (sec. 318(d)(1)(D) (42 U.S.C. 247c)).

B. FDA

1. Toy safety eduaction (PHS Act. sec. 315).
2. Nutrition labeling education (PHS Act, sec. 315).
3. Over-the-counter drugs education (PHS Act, sec. 315).

C. HRA

1. Uses secs. 301 and 315 of PHS Act (which are applied in a very general way by PHS programs).

2. Public Law 93-641, National Health Planning and Resources Development Act of 1974.

D. HSA

1. Federal employee health (5 USC 7901).
2. Emergency Medical Services Act (93-154, sec. 1206).
3. Federal employee alcoholism program (PHS Act, sec. 201(a)).
4. Health maintenance organizations (PHS Act, sec. 1301(c)).
5. Family planning (PHS Act, sec. 1005(a)).
6. Migrant health (PHS Act, Sec. 310).
7. Maternal and child health (PHS Act, sec. 315, title V, SSA).
8. Neighborhood health centers (PHS Act, sec. 314(e)).
9. Indian health services (PHS Act, sec. 315).

E. NIH

1. National Cancer Act (Public Law 92-218, sec. 407(a)(4)).

2. National Cancer Act, Amendments of 1974 (Public Law 93-352).

3. National Heart, Blood Vessel, and Blood Act of 1972 (Public Law 93-423, sec. 413 (a) (?), and(d)).

4. Research on Aging Act of 1974 (Public Law 93-296, sec. 463(c)).

5. Diabetes Mellitus Research and Education Act (Public Law 93-354, sec. 2 (a)(11 and (b)(2)(B); sec. 3(e)(1)).

6. Arthritis Act (Public Law 93-640, Jan. 4, 1975) National Arthritis Act of 1974.

F. ADAMHA

1. PHS Act, sec. 301(a).
2. PHS Act, sec. 315 (42 U.S.C. 247).

3. Public Law 92-255, sec. 406(a)—Drug Abuse Office and Treatment Act of 1972.

4. Public Law 93-262, sec. 311(a)(1), (2), (3), and (4) of title I (Federal assistance for State and local alcoholism and alcoholic abuse programs).

5. Public Law 93-282, sec. 455(a), 101(a) and 284 of title II (administration and coordination of the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse).

II. OFFICE OF CONSUMER AFFAIRS/OS

1. Executive order 11583.

III. OFFICE OF EDUCATION

1. Vocational Education—Consumer and Homemaking, Vocational Education Act of 1963, Public Law 88-210, title I, 77 Stat. 403, as added; Public Law 90-336, title I, sec. 101(b), 82 Stat. 3085, 20 U.S.C. 1341 (1968), as amended; Public Law 92-316, title II, sec. 205, 86 Stat. 326, 20 USC, 1361 (1972).

2. Educationally Deprived Children—Handicapped Elementary, and Secondary Education Act of 1965, Public Law 89-10, 79 Stat. 27, as amended; Public Law 89-750, title I, sec. 161, 80 Stat. 1204, 20 U.S.C., 861 (1966), as amended; Public Law 91-230, title IV, sec. 611, 84 Stat, 178, 20 U.S.C. 1411 (1970).

3. School Health and Nutrition Services for Children from Low-Income Families, Act of April 23, 1970, Public Law 91-230, title I, sec. 164, 84 Stat. 153, 20 U.S.C. 887a (1970) To be consolidated—Public Law 93-380, title IV, part C.

4. Follow Through, Economic Opportunity Act of 1964, Public LIaw 88-452, 78 Stat. 508, as amended; Public Law 90-222, title I, sec. 104, 81 Stat. 698, 42 U.S.C. 2809(a)(2) (1967), as amended; Public Law 92-424, secs. 8-11, 86 Stat. 690, 691, 42 U.S.C. 2809(a)(2) (1972).

5. Drug Abuse Prevention, Drug Abuse Educational Act of 1970, Public Law 91-527, sec. 3, 4, 5, 84 Stat. 1386, 1387, 1388, 21 U.S.C. 1002 1003 1004 (1970). Alcohol and Drug Abuse Education Act amendments of 1974. 21 U.S.C. 1001 note.

IV. OFFICE OF HUMAN DEVELOPMENT/OS

1. Sec. 222(a)(1) of the Economic Opportunity Act of 1964, as amended, provides for child health and nutrition education programs.

2. Sec. 903(g)(7) of the regulations for implementation of the Older Americans Act addresses itself to health education.

V. SOCIAL REHABILITATION SERVICES

1. Social Security Act (medicaid—title XIX. (*a*) Early and periodic screening, diagnosis, and treatment (1905(a)(4) and (*b*) Family planning (1905(a)(4)).

Mr. FLOOD. What are you doing to involve the private sector, insurance companies and drug companies? How are you getting them into the act?

Dr. SENCER. This would be through the proposed National Center for Health Education.

Mr. FLOOD. What is the status of that?

Dr. SENCER. That report is due to us on May 2, from the contractor.

Mr. FLOOD. What are you doing to involve these drug companies and insurance companies?

Dr. SENCER. We are trying to see if it is possible to not involve them because they are involved but to find a way in which we can coordinate their efforts so we do not have hypertension competing with cancer on the same day.

Mr. FLOOD. That decision will be in the later part of calendar 1975.

Dr. SENCER. We hope to have a decision as to whether the external agency approach is a feasible one by the end of this fiscal year.

TRAVEL

Mr. FLOOD. Now, you have a budget for travel for $3,097,000. That is about $900 a year per man. Why do you need all that money to travel? You might meet yourself coming back.

Dr. SENCER. The nature of our work is that we travel to do it.

Mr. FLOOD. How much of that money is running back and forth between Washington and Atlanta?

Dr. SENCER. I think we looked that up not long ago.

Mr. FLOOD. Good. Put that in the record for fiscal year 1974, anyhow.

How much of this is that commuter business between Washington and Atlanta?

[The information follows:]

The CDC's accounting records are not designed to account for travel cost by locations visited, however, we estimate that $177,000 (5.8 percent) was spent on travel between Atlanta, and the Washington, D.C., area in 1974. Of this amount, we estimate $40,000 was for management type travel, the rest of the travel was for scientific or program type travel.

Mr. FLOOD. Now I want a detailed analysis of how that amount of $3,097,000 for travel was computed. Now take your time on that.

[The information follows:]

The Center's principal mission is to assist State and local health authorities and other health related organizations in stemming the spread of communicable diseases, in providing protection from some environmental hazards, and improving occupational safety and health. To accomplish this mission, the Center is required to perform travel for several reasons.

Travel is required for investigations and the development and evaluation of new methods of controlling or preventing diseases.

The Center maintains a cadre of epidemic intelligence officers that are available for epidemics occurring not only in the United States but throughout the world. Travel costs are kept to a minimum by stationing these officers in various State and local health agencies throughout the country. During 1974 there were 1,250 epidemic and outbreak investigations conducted. Approximately 1,250 separate disease outbreaks will be investigated during 1975 in collaboration with local health workers, and an estimated 1,500 such investigations will be conducted during 1976.

These officers are members of the Public Health Service and serve for a minimum of 2 years. This requires the payment of travel for officers separating and entering the service each year.

The Center provides technical consultation and assistance in all aspects of disease control. The Center expertise is available to State and local agencies in the areas of VD, immunization, rat control, lead-based paint poisoning, youth camp safety, and other environmental health areas and to assist States in conducting training courses related to disease control. Professional CDC personnel are required to travel when attending professional meetings and seminars, giving lectures before various professional groups and attending training courses for the purpose of disseminating scientific or health information. Site visits are required by program personnel to review and assess grants and contracts. Also site visits are required by contracting and cost advisory personnel when negotiating contracts.

The active surveillance of disease and reporting on trends and developments in order to prevent disease is an objective of this agency. To accomplish this objective, strict surveillance of contagious and hazardous diseases is essential. Surveillance and control of diseases of foreign origin is advantageous in disease prevention since this can be accomplished before they become a health problem in this country.

Each area of travel was examined in detail to determine the travel requirement for 1976. For example, our estimate for officers entering the service and separating is based on estimates of transportation from or to their duty stations based on our experience in 1974 and 1975 with like travel. The number of epidemics and hazard investigations are estimated and the required travel necessary for their trips based on past experience. This type of estimating is done for each type of travel cost we incur to provide a good estimate for 1976.

The Center is responsible for on-site inspection and licensing clinical laboratories engaged in interstate commerce, as well as working with State public health labs to update laboratory performances.

The Center provides leadership and coordination of a national health education program aimed at preventing disease, disability, premature death, and undesir-

able and unnecessary health events. Educational activities are coordinated with those of the many medical, civic, and educational groups which share the Government's concerns.

NIOSH major objectives and responsibilities are to conduct the research necessary to develop recommended occupational safety and health standards for submission to the Department of Labor, to set health standards for coal miners, to conduct industry-wide epidemiological studies, to stimulate occupational health and safety programs in State and local governments and in industry, and to provide technical assistance and training. NIOSH is required by law to respond to requests from employers or authorized representatives of employees for determination of whether substances normally found in place of employment have potentially toxic effects.

During 1974 and early 1975 the Center adopted a number of travel saving policies. As a result, we have revised our travel estimate from the $3,513,000 in the 1975 budget estimates to $3,097,000 as shown in the 1975 column of the 1976 budget request. By planning each trip to achieve the greatest return with the lowest cost, we are not asking for any increase in 1976.

Mr. NATCHER (presiding). Mr. Obey?

Mr. OBEY. Thank you, Mr. Chairman.

Doctor, before I start, I just want to say a few things. I have been, as you know, quite critical of the way the whole occupational health program has been run. I do not want you or anybody else to think that reflects upon you because I think you are a good administrator and I think you know what you are doing and I think you are a good public servant.

Dr. SENCER. Thank you.

Mr. OBEY. I just think that perhaps the administrative structure under which NIOSH operates and the restrictions by OMB have given you a pretty tough job to handle. I want you to understand that before I start.

Let me ask you a couple of questions before I get to NIOSH.

IMMUNIZATION

Let me ask you about immunization levels in light of the reduction in the budget.

It is my impression that immunization levels for polio and diphtheria, whooping cough and tetanus have declined to their lowest levels in a decade. Is that correct or not?

Dr. SENCER. That was our testimony last year, Mr. Obey. This year in the September survey that is annually taken for us by the Bureau of the Census the percentage of children immunized against polio has gone up as has DPT, measles and rubella.

Mr. OBEY. To what percentage?

Dr. SENCER. Sixty-three percent of pre-school children have received optimal immunization against polio. Seventy-four percent received diphtheria immunization and 65 percent received measles immunization and 60 percent immunized against German measles.

SMOKING

Mr. OBEY. On page 153 of your justifications it says: "In 1976 the Center will continue and strengthen major education efforts to help reduce the health consequence of smoking. In the United States each year there are 25,000 deaths from lung cancer, I million from cardiovascular disease. Cigarette smoking is a major contributing factor in those diseases yet over one-third of the adult population continues to smoke."

I agree those are impressive statistics. I know it is hard to get a handle on the figures, but what do you think would be a ballpark figure for the number of people who die from occupational diseases each year?

Dr. Sencer. The estimates have been made that there are 100,000 deaths a year from occupationally related diseases and injuries.

Mr. Obey. Isn't it true that the danger of contracting fatal diseases for smokers is much greater if they are exposed to occupational or environmental hazards?

Dr. Sencer. Yes.

This has been documented in a good number of industries. One of the collaborative projects we have with the Cancer Institute, NIOSH and the Bureau of Health Education is to get up a model anti-smoking program in Tyler, Tex., where the asbestos and lung cancer relationship was so well demonstrated.

Mr. Obey. Let me make an observation before I go into my questioning on NIOSH.

The reason I am so interested in the area of worker health is because it seems to me that if workers understood what some of the findings are about the potential for occupational diseases in the many industries, if they understood that the concern for the environment, for instances, encompasses not just concern for trees and fish, but also concern for human beings who work in shops, steel mills, textile mills and on the farm you name it I think if they truly understood the implications of this whole problem, there would not just be coal miners marching around this building today, there would be a lot of other workers raising hell as well.

Dr. Stone, a past Director of NIH stated that most known environmental carcinogens are a result of our increased agricultural and industrial technology. Dr. Cotten, Vice President for Medical Affairs at Johns Mansville Corp., projected an annual cost of $35 billion for environmentally induced diseases.

You can go on and on. I was up in New York a couple of weeks ago. I noted in one of the papers delivered there a quote from George Bernard Shaw that says, "The worst sin toward our fellow creatures is not to hate them, but to be indifferent toward them. That is the essence of inhumanity."

It seems to me that OMB in determining budgets for worker health budgets over the years has not been vicious or venal. They just haven't really cared. If you read OMB's narrative, they express concern with the tragic vinylchloride episode and say that "The Institute should vigorously attack the problem related to exposure to potential carcinogens in the workplace." I am reminded of the old saying "What you do speaks so loudly I cannot hear what you say."

If you look at this budget that sense of urgency is not in any way reflected. I wonder if you would define for me the job of NIOSH as you see it.

Dr. Sencer. I think the job at NIOSH is to be the principal Federal agency that investigates the environment of the workplace to determine what hazards are there, both as they relate to disease and also

to safety. It is principally a professional organization that is to provide to the enforcement organization, the Department of Labor, the professional grounds upon which to build standards that can be enforced to assure that the workplace is as healthy as we know how to make it. It also has major responsibility for the health of coal miners under the Coal Mine Safety and Health Act. I think a lot of the attention that has been placed in NIOSH in the past has been over one of its responsibilities which is the development of criteria documents as they have become known. I think that that concern, while an important one, has caused sight to be lost of some of the other valuable, worthwhile and important things that they do to improve the health of workers.

For example, there has been very little said about the hazard assessment that is being completed at the present time where a statistical sample of all work places was developed and a thorough investigation of potential problems were made there.

They provide a great deal of technical assistance to industry, both labor and management, concerning potential health hazards. One such example relates to the problem of informing the worker of potential dangers. NIOSH is developing a series of manuals that tell in simple terms what the type of occupational hazards are and what the employers and employees can do to make it a safer operation. NIOSH is conducting industrywide surveys to find these hazards. If you were at the New York meeting, you probably heard about five of these at that time.

Mr. MILLER. Since OMB is not here to defend itself, I would like to put in a couple of words on their behalf. I think you said they singled this out for cuts because they are indifferent.

Mr. OBEY. No. I said they have indicated by words that the problem is serious, but they have not acted that way with their budget recommendations. I don't say NIOSH is being singled out. I say they are being ignored.

Mr. MILLER. But in a budget which generally reduces the Federal role in health programs and where there are a series of reductions, NIOSH has been increased. So, I think, they would say the program does have a priority on the Federal dollar. I recognize from your perspective, it does not come out that way.

Mr. OBEY. Doctor, you are saying NIOSH is the front line of defense for American workers in terms of Government action to protect their health in the work place, right?

Dr. SENCER. If you saw the coalminers, today, most of them were wearing hard hats. These were certified, to be safe, by NIOSH as one of its legal responsibilities to be safe. Many of the lesser known responsibilities contribute to a healthier work place.

Mr. OBEY. I want to confine my questions to the occupational health as compared to the occupational safety aspects of NIOSH.

I think they are in a sense two different issues. You run into so much controversy on the other one that I do not want to get this tangled into that.

TOXIC SUBSTANCES

Let me ask you this: What is the universe, the reasonable universe of chemicals we ought to be investigating? Last year I think you indicated that it was somewhere around 2,000.

Dr. SENCER. The toxic substance list, those things that are known to be toxic in some form or another, is considerably more than that.

There are 44,000 entries in the toxic substance list. The NIOSH list of priorities of chemicals that need to be addressed, there are 471, I believe.

Mr. OBEY. Could you tell us and insert in the record what divisions of NIOSH are located where in the country?

I think last year on page 292 you listed the same information which I would like you to insert this time.

Dr. SENCER. All right.

It is in the record, I know, from last year. They are the functional statements of the organization.

Mr. OBEY. Yes.

[The information follows:]

FUNCTIONAL RESPONSIBILITY BY GEOGRAPHIC LOCATION

Rockville, Md. (Headquarters), has responsibilities for overall administration and policy development including planning and resource management, Office of Technical Publications, and Extramural Activities. In addition, the Offices of Research and Standards Development, Occupational Health, and Health Surveillance and Biometrics are located in Rockville.

The Cincinnati, Ohio, office is responsible for basic laboratory research for criteria development, laboratory services, and quality control, field studies and clinical investigations, technical services, and manpower development and training activities. Also, portions of the Office of Extramural Activities, Technical Publications, and Administrative Management are located in this office.

The Morgantown, W. Va., facility houses the Appalachian Laboratory for Occupational Respiratory Diseases (ALFORD) and the Testing and Certification Laboratory which are primarily concerned with occupational respiratory diseases with emphasis on coal and the testing and certification of industrial hygiene sampling equipment and personal protective devices.

The Salt Lake City, Utah, facility provides laboratory support for analytical chemical services for the Department of Labor's Occupational Safety and Health Administration (OSHA) as well as the Institute's focus for agricultural research and new energy initiatives.

OFFICE/DIVISION BY GEOGRAPHIC LOCATION

Organization and location

Office of the Director, Rockville, Md.; (Cincinnati, Ohio); and (Morgantown, W. Va.).*

Regions, 10 regional offices.

Office of Technical Publications, Rockville, Md.; (Cincinnati, Ohio*); and (Morgantown, W. Va.).*

Office of Extramural Activities, Cincinnati, Ohio and (Rockville, Md.).*

Office of Administrative Management, Rockville, Md., and (Cincinnati, Ohio).*

Office of Planning and Resource Management, Rockville, Md., and (Cincinnati, Ohio).*

Office of Research and Standards Development, Rockville, Md., and (Cincinnati, Ohio).*

Office of Health Surveillance and Biometrics, Rockville, Md.

Division of Laboratory and Criteria Development (testing and certification laboratory), Cincinnati, Ohio and (Morgantown, W. Va.).*

Division of Field Studies and Clinical Investigation, Cincinnati, Ohio and (Salt Lake City, Utah).*

Division of Technical Services, Cincinnati, Ohio and (Salt Lake City, Utah).*

Western Area Laboratory for Occupational Safety and Health, Salt Lake City, Utah.

Division of Occupational Health Programs, Rockville, Md.

Division of Training, Cincinnati, Ohio.

Office of Manpower Development, Rockville, Md.

Appalachian Laboratory for Occupational Respiratory Diseases, Morgantown, W. Va.

*Parenthesized cities are where staff activities occur also.

Physical Facilities

Mr. Obey. Let me ask you about your physical facilities. When will the Department relocate your research efforts into safe and adequate facilities?

Dr. Sencer. This breaks down into two problems: One is an immediate problem and the other is a long-range problem. The immediate problem we have in the Cincinnati area where the largest of the laboratory activities are conducted is that we are in facilities now that are unsafe.

We have been investigating space that has been occupied by the Environmental Protection Agency that will become available shortly. We thought this was going to be a temporary solution to our problem but we now find there have been studies of that facility which indicate it does not meet safety standards. We have a team there today trying to determine how adequate they are.

The long-range problem is to find a site for a new building. No money has been appropriated as yet for new construction.

Mr. Obey. What is the situation with the contract for the new building? You told us last year that the contract had been let.

Dr. Sencer. I misspoke. The contract had left our hands and I thought it had been let. There has been a contract let last month with A. M. Kinney & Associates who are doing conceptual design and functional layouts. This is not design of an actual facility or construction, but an attempt to see what we are going to need with the projected growth and activities of NIOSH.

Mr. Obey. What is your estimate on how long it will be before that building is built, if you assume it is going to be built in Cincinnati?

Dr. Sencer. The way construction normally goes, we would be coming in next year for funds and have 4 to 5 years of construction time. This is not office space. It cannot be designed as you build it. It is complicated space and will take 5 to 7 years.

Mr. Obey. Have you surveyed Federal laboratory facilities nationwide to determine whether there would be facilities in Cincinnati, Denver, or anyplace else?

Dr. Sencer. We've looked in Houston in the Research Triangle, Manville, N.J., Santa Clara, Cincinnati, and Tucson and Pittsburgh we have been unable to find anything that would be superior to the Cincinnati proposal.

Mr. Obey. What about the use of temporary space?

What about the facility at Ridge Avenue?

Dr. Sencer. This is the one EPA had been in and we now get reports that it is unsafe space. We have not verified that. We are looking at it today to see if it would meet the minimum safety standards.

One of the problems of temporary space is that there are limits on the amount of money you can spend to refurbish rented or leased space. Just about any type of space we can find now that has not previously been a laboratory, the cost of renovation would probably preclude us from doing this.

Mr. Miller. Mr. Obey, knowing your penchant for reading hearings from the previous year, I want to make it clear that when Dr. Sencer discussed the time schedule for construction and how long it will take

it was done in the context of if we request construction funds in fiscal 1977, but that is not a commitment that we will.

Mr. OBEY. I understand. That is part of the problem.

Doctor, would you insert for the record also the same information you inserted on page 295 of last year's hearings, the NIOSH budget by office and division for both fiscal 1975 and 1976? The appropriated level is 1975. Would you also insert the updated information found in last year's hearings on page 296, the NIOSH budget by function for fiscal 1975 and 1976?

Dr. SENCER. Yes, sir.

[The information follows:]

NIOSH 1975 BUDGET BY OFFICE AND DIVISION

[Dollar amounts in millions]

Organization	Budgeted positions	Amount
Office of the Director	78	$2.0
Office of Technical Publications	10	.2
Office of Extramural Activities	12	4.5
Office of Administrative Management	45	1.9
Office of Planning and Resource Management	11	.7
Office of Research and Standards Development	68	4.2
Office of Manpower Development	3	.1
Office of Occupational Health Surveillance and Biometrics	30	2.3
Division of Laboratory and Criteria Development	212	7.8
Division of Field Studies and Clinical Investigations	63	3.5
Division of Occupational Health Programs	11	.6
Division of Training	22	.7
Regions	34	.8
Division of Technical Services	64	1.9
Appalachian Laboratory for Occupational Respiratory Diseases	81	2.8
Total	744	34.0
Occupational health	660	32.0
Program management	75	2.0
Reimbursements	9	----

NIOSH 1975-76 BUDGET BY FUNCTION (PROGRAM AREA)

[Dollar amounts in millions]

	1975 appropriation		1976 budget	
	Positions	Amount	Positions	Amount
Program administration and support	137	$3.0	137	$3.2
Research and standards development	366	22.8	379	24.4
Technical assistance and services	207	5.1	207	5.5
Manpower development	34	3.1	34	1.2
Total	744	34.0	757	34.3
Occupational health	660	32.0	673	32.2
Program management	75	2.0	75	2.1
Reimbursements	9	----	9	----

BUDGET REQUEST AND ALLOWANCES

Mr. OBEY. Now, would you tell me what was the budget request which NIOSH originally recommended to CDC?

Dr. SENCER. $42,886,000.

Mr. OBEY. And as it left CDC for the Department?

Dr. SENCER. It is the same.

Mr. OBEY. So you did not cut a dime?

Dr. SENCER. No, sir.

Mr. OBEY. When it came back from OMB it was $32 million?

Dr. SENCER. $32,181,000.

Mr. MILLER. The Department sent it at $36.7 million.

Mr. OBEY. The appropriated level last year in comparison to the $32,181,000 was what?

Dr. SENCER. $31,986,000.

Mr. OBEY. Which is an increase of what?

Dr. SENCER. $195,000.

Mr. OBEY. Where were those cuts, if you compare what NIOSH sent to you and what you got back from OMB?

Dr. SENCER. The Department reduced $6,100,000 principally in occupational carcinogenesis and in research and training grants.

The OMB made a further reduction of $4.6 million in the direct operations for occupational carcinogenesis.

Mr. OBEY. So the total reduction for occupational carcinogenesis was what?

Dr. SENCER. $11 million, roughly, sir.

Mr. OBEY. And that was carrying out the statement of the OMB narrative that "It is imperative that the Institute vigorously attack the problem related to exposure to potential carcinogens in the work place?"

Could you go into some detail on exactly what those cuts represented?

What did they do, for instance, on criteria documentation?

Dr. SENCER. The actual influence on immediate development of criteria documents was not particularly affected by this budget because the program that was aimed at detecting those things which were potentially or actually carcinogenic in the work place would have led then to documentation.

The principal area we wanted to undertake was to increase the field studies in the actual working environment to find out what was being used and what was a particular problem.

CRITERIA DOCUMENTS

Mr. OBEY. I will get to the field study question later but could you tell me now because there was a little bit of confusion in the hearings on deferrals and rescissions, the number of criteria documents which you expect to have prepared in fiscal 1975?

Dr. SENCER. So far in fiscal 1975 we have transmitted to the Department of Labor seven and we have at least seven more that will be transmitted this fiscal year. We could possibly have a total of 18, four more than that.

This would be due to the fact that some of them were scheduled for previous years and have slipped in this year.

We think we will get a total of 18 to the Department of Labor.

Mr. OBEY. If we provide money for criteria document preparation in fiscal 1975, you are generally talking about a document which is produced in what fiscal year?

Dr. SENCER. 1977.

Mr. OBEY. So there is a 2-year lag?

Dr. SENCER. Yes.

Mr. OBEY. How many criteria documents do you envision being prepared under your budget for fiscal 1976?

Dr. SENCER. In fiscal 1976 we expect 14 criteria documents to be transmitted.

Mr. OBEY. So that would be four less than your expectation for this fiscal year if things work out all right.

Dr. SENCER. That is because for this fiscal year we had some for past fiscal years.

Mr. OBEY. If we accept your budget, what do you expect to be the number produced in fiscal 1978?

Dr. SENCER. Twenty-six would be both in 1977 and in 1978.

Mr. OBEY. Because of the long time it takes to prepare criteria documents and several other reasons, you are trying to prepare some mini-standards. What is the story with those?

Dr. SENCER. These are standards prepared under the authority of the Occupational Safety and Health Act. We have been calling them supplementary standards. They are now being referred to as standard completions. These are taking limits that have been published in the Federal Register for a variety of substances in the workplace and in cooperation with the Department of Labor translating these into an enforcible number and method of enforcement in the workplace. There are about 400 such subjects where threshold limits have been put forth in the Federal Register. We envision this as being a 2-year effort with the Department of Labor to turn these into standards.

Mr. OBEY. I will come back to that in a minute.

Do you want to go ahead and finish what you started telling me before about the major cuts?

FIELD STUDIES

Dr. SENCER. The major emphasis in our major proposal on occupational carcinogenesis was to implement the field studies that were necessary to identify materials that are potentially carcinogenic before we are faced with outbreaks of neoplasms.

I think one of the best ways to demonstrate the way we would have been allocating our resources, we had 71 positions for field studies which we would have used as against 5 for standards development. So the principal effort would have been the field studies.

Mr. OBEY. Would you insert in the record at this point what the dollar amounts and the positions would have been for each of the divisions and for each of the functions, the same as the other two charts, had the original NIOSH budget been approved as recommended and then show in detail what those reductions would be from that level because of the cutbacks by HEW and OMB.

Dr. SENCER. The way we developed it was in terms of allocating it to an activity rather than to an actual organizational chart at that time.

I think if we were to tell you now it would really be in retrospect because in the development of our budget we only worked at activities such as surveillance, laboratories, field resource, et cetera.

Mr. OBEY. Would you submit, for those categories, what the reductions were?

[The information follows:]

1976 PREVENTIVE HEALTH SERVICES

OCCUPATIONAL HEALTH ACTIVITY BUDGET REQUESTS AND REDUCTIONS BY FUNCTION

[In millions of dollars]

	CDC estimate to DHEW	DHEW change	DHEW estimate to OMB	OMB change	President's budget
Program administration and support	1.8	+0.1	1.9		1.9
Research and standard development	[1] 32.9	−3.9	[2] 29.0	−4.6	[3] 24.4
Technical assistance and services	5.0	−.4	4.6	+.1	4.7
Manpower development	3.2	−2.0	1.2		1.2
Total	42.9	−6.2	36.7	−4.5	32.2

[1] The CDC estimate to DHEW would have permitted $9,700,000 for a comprehensive research program for occupational carcinogenesis.
[2] The DHEW estimate to OMB would have permitted $7,700,000 for a comprehensive research program for occupational carcinogenesis.
[3] The President's budget would permit $1,300,000 for a comprehensive research program for occupational carcinogenesis.

End of Year Ceiling

Mr. Obey. What is the current end of year ceiling for NIOSH?

Dr. Sencer. We have two end of year ceilings, really. We have one which reflects positions budgeted against occupational health and those in program management. The end of year ceiling for occupational health is 644 and for program management, 75.

Mr. Obey. Let me ask you about the way they are listed in the budget because if you remember in the hearings on rescissions and deferrals there was some confusion between you and me and I think Mr. Miller as to what the ceilings were.

The first response you gave to me, did or did not include the 77 people from program management?

I would prefer if you would give it to me strictly in terms of what is available to NIOSH, rather than mixing in the program management people.

I found that very confusing. If you want to do it both ways, fine, just so we have the two tables in the record.

Dr. Sencer. All right.

The end of year ceiling for direct operations of NIOSH is 644.

Mr. Obey. How many vacancies do you have now?

Dr. Sencer. We have on duty 528 with 26 commitments.

Mr. Obey. So the vacancies are what, not counting the commitments?

Dr. Sencer. 90.

Mr. Obey. How many do you think you will have by the end of fiscal year?

Dr. Sencer. We estimate we will have 613 on duty by the end of the fiscal year.

Mr. Obey. Which of the critical manpower skills are difficult to recruit for?

Dr. Sencer. Industrial hygienists, toxicologists, and epidemiologists.

Mr. Obey. Does NIOSH still have a problem with grade restrictions preventing them from hiring qualified personnel?

Dr. Sencer. No, sir, this is not a problem at the present time.

Mr. Obey. I want to congratulate you on that.

I am pleased to see that.

Training Grants

What about training grants? We discussed this several weeks ago, but I would like it in the record again.

In light of the alleged shortage in skilled manpower needs in several areas, how can we justify funding training grants for only 1 year?

Dr. Sencer. That is difficult to respond to as we have discussed before. We have tried to use these to stimulate the development of curricula materials rather than the actual support of trainees. With only 1 year's money, we felt that this was the most effective way that we could use the funds.

Mr. Obey. So you cannot assure this committee with any degree of certainty that even the limited manpower problems of NIOSH would be met under this budget?

Dr. Sencer. I think the training grants were more to develop individuals not to work for NIOSH, but to work broadly in the field of occupational health. So I do not think our difficulty in recruitment should be linked to not having training grants.

Mr. Obey. Would you tell me this? Do you have any idea of how many occupational physicians are floating around the country right now? What is the estimate of need?

Dr. Sencer. A guesstimate would be about 1,200.

Mr. Obey. How about industrial physicians?

Dr. Sencer. There are 2,700 who have had some short-term specialized training at the present time and we estimate 4,200 would be necessary.

Mr. Obey. Would you supply for the record what those same figures would be, those available versus the guesstimate of need for occupational safety and health professionals, occupational health nurses, other nurses and technicians and anything else you want to add.

[The information follows:]

ESTIMATED OCCUPATIONAL SAFETY AND HEALTH MANPOWER DEFICIT

	Present census	Defici
Occupational physicians, board qualified or certified	500	1, 200
Industrial physicians, with special short-term training	2, 700	4, 200
Occupational safety and health professions	3, 700	8, 530
Industrial hygienists (certified, ABIH)	770	3, 830
Safety specialists (certified, ASSE)	3, 000	4, 700
Occupational health nurses (certified AOHN) [1]	1, 000	8, 400
Other nurses (on-the-job training) [1]	17, 000	19, 700
OSH technicians [2]	15, 000	8, 800
Total	39, 970	50, 830

[1] Includes equally qualified physician assistants.
[2] Includes those working in safety or industrial hygiene who are not now board certified.

Mr. Obey. At this point I would like to have inserted Secretary Richardson's letter again. It is getting to be an old friend in the record.

[The information follows:]

SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., July 25, 1972.

Hon. WARREN G. MAGNUSON,
Chairman, Subcommittee on Labor and Health, Education, and Welfare, Committee on Appropriations, U.S. Senate, Washington, D.C.

DEAR SENATOR MAGNUSON: This supplements the tabulation submitted by this Department to your subcommittee staff in the anticipation of the meeting of the conferees on the Labor-HEW 1973 appropriations bill.

I would like to emphasize, first, that the increases in both the House and Senate versions of the bill are a matter of serious concern in the light of the overall budgetary situation. On the basis of our detailed arguments in the tabulation, I urge that the action of the conferees be held to the lower of the House- or Senate-passed levels on an item-by-item basis.

There is, however, one exception which I particularly want to bring to your attention: the appropriation for the occupational health and safety activities of the Health Services and Mental Health Administration.

Since the budget was submitted, I have become very concerned about the rate at which new health and safety standards are being promulgated. We have so far recommended only five such standards: asbestos, beryllium, carbon monoxide, heat stress, and noise. The budget estimate was built on the assumption that we would recommend 20–30 additional standards in fiscal year 1973. I now feel that we should accelerate this pace to 40–60 standards.

The budget requested and the House approved $28,842,000 for occupational safety and health activities of the Department. The Senate bill, however, contains $63,842,000, $35 million more than the House allowance and the budget request. I would urge you and the other Senate conferees to retain $10 million of the Senate increase over the budget so that the production of safety standards can be accelerated. The protection of the health and safety of millions of men and women at their places of work makes it imperative that we develop and promulgate health and safety standards as rapidly as we possibly can.

With kindest regards,
Sincerely,

ELLIOT RICHARDSON,
Secretary.

CRITERIA DOCUMENTS

Mr. OBEY. As you know, Secretary Richardson indicated to the committee a couple of years ago that 40 to 60 criteria documents should be prepared annually. I know there are other programs that may be more important, field studies, for instance, but what resources would be required to actually produce that number of criteria packages in any 1 fiscal year?

Dr. SENCER. I am not sure that the limitation on resources is the important thing. NIOSH has attempted to maintain a high quality of review and make sure that the criteria are developed in an equitable manner from one criteria to another. In the review process the time that this takes, the top level attention that this takes, it is their belief that the level that they are aiming at of 26 per year is probably the state of the art today without changing the review criteria and diminishing the standards.

Mr. OBEY. How did Secretary Richardson come to the "erroneous" conclusion that you could produce more?

Dr. SENCER. We had not produced any when he came up with that estimate, or maybe one or two, and we have learned from experience.

Mr. OBEY. How many years is it going to take?

Last year you mentioned that there were about 2,000 chemicals which you were especially concerned about.

How long is it going to take to get this documentation out?

Dr. SENCER. I think that points out some of the dangers in saying what we are going to be concerned about.

If you look at the priority list, derived from known knowledge, vinylchloride would have been the 206th on the list. But suddenly that becomes a problem. That is why I think we have to equate criteria documents to the field studies and development of new knowledge so we are not caught with vinylchloride and the arsenics coming along and locking the barn after the horse is out.

Mr. OBEY. How many ministandards are out?

Dr. SENCER. Four hundred are anticipated. We expect the first group of six to come into the Federal Register in the next couple of weeks. Then they will begin coming quite rapidly.

Mr. OBEY. Can this committee be certain they will be promulgated and enforced?

Are there any potential difficulties, legal or otherwise, connected with it?

Dr. SENCER. Could I ask Mr. Baier to answer that?

Mr. BAIER. We have been working in NIOSH with the Occupational Safety and Health Administration.

The completed product is our standards. It is hard to say at this point whether or not anyone will ask for public hearings or a whole 6–B rulemaking procedure under the Occupational Safety and Health Act. That could delay some of these.

As far as we are concerned, they are coming into the pipeline and we should have at least 100 ready to go through the legal process by the end of the fiscal year.

Dr. SENCER. It is hard to guarantee to the committee that this will take place. With the vinylchlorides the court threw them out on the basis that detecting devices were not available. It was not that there was anything wrong with the standards, but the courts felt we should have a standard because no detecting devices were available.

Mr. OBEY. What assurance can the committee have that you will not run into legal problems on the others as you produce them?

Dr. SENCER. None.

Mr. BAIER. We cannot assure it from our vantage point nor can the Occupational Safety and Health Administration assure it. It depends on the rulemaking procedure that anyone can ask for a public hearing and anyone can have the right to take it to court. We don't expect it to happen.

HAZARD EVALUATION

Mr. OBEY. What about hazard evaluations? Has NIOSH honored all of the requests for hazard evaluations and consultations?

Dr. SENCER. We have honored them.

There are some that we are not able legally to respond to because the way the law was developed only hazards that relate to toxic substances can be dealt with. Hazards relating to heat, noise——

Mr. OBEY. How much trouble do you run into explaining that to people?

Dr. SENCER. Let me ask Mr. Baier to speak to that.

Mr. BAIER. Quite a bit. It is not very well understood. What we have been doing, if we locate these in connection with another type of a hazard evaluation request, we certainly provide the technical information. It would require a rewrite of the act to give us legal author-

ity into, let's say, the nontoxic substances, in other words, the physical agent kind of things.

Mr. OBEY. Do you think that would be sensible?

Mr. BAIER. Well, I think we are covering it pretty well with consultative services rather than a hazard evaluation, according to the specific type of thing.

Mr. OBEY. Why does it take you so long to report your findings for health hazard evaluations?

Mr. BAIER. Actually on an average, it looks long. On occasion we can do it very rapidly. On other occasions it takes a very long time. The reason for this is the nature of the particular hazard. For instance, if it is something we are familiar with like carbon monoxide or carbon tetrachloride, the more common chemical agents, we can evaluate it very rapidly. On the other hand, we come across substances like DES for which there is no standard at the present time. This requires a lot of literature search. We have to develop a small criteria document. We have to develop medical strategy to evaluate exposures. We sometimes have to develop sampling procedures to evaluate the exposure and an analytial procedure, all of which does take time. On an average it is not too bad, but we do have the two extremes, that is true.

CANCERS OF OCCUPATIONAL ORIGIN

Mr. OBEY. Dr. Sencer, let me ask you, in a past hearing Dr. Stone said "Industrial and agricultural technologies are the major contributors in the production of most known environmental carcinogens." NIOSH itself wanted to decrease by 1980 newly-induced cancers of occupational origin by 10 percent.

Given this budget, what do you think a reasonable expectation is going to be as far as that reduction is concerned?

Dr. SENCER. I'm sure we are not going to reach 10 percent reduction. I think that we would hope to be able to identify in the next 5 years significant numbers of new environmental carcinogens in the work place. We are going to be able this year to undertake with the budget three new field studies of industries that we would anticipate would have a high potential for risk.

Mr. OBEY. You do not want to venture a guess?

Dr. SENCER. No. I might be like Secretary Richardson.

Mr. OBEY. What could I guess? Don't you think it is likely that because of the tremendous field and the increasing number of really horrifying discoveries that you are likely to have a greater instance of occupational cancer by 1980 than you have now?

Dr. SENCER. Yes. I think that 10 percent would have to be from things we knew were carcinogenic and in the next 5 years we will have more things come to our attention that are carcinogenic. If we are able to reduce the risk, this will be balanced off by other things coming into the environment.

Mr. OBEY. So we will be lucky if we stay the same.

Dr. SENCER. That is right.

One thing that no one has begun to look at except in the case of lung cancer, where you find the potential tie-in with cigarette smoking and environmental factors, I think as more and more things come into the environment, we will see interactions where one thing may be per-

fectly safe and you get another substance in the food chain or in the air and they will potentiate each other.

Mr. OBEY. I wonder if you would for the committee just outline very briefly and supply for the record in much greater detail what some of the more worrisome scientific revelations have been in the last year or two as far as occupational agents are concerned?

[The information follows:]

BRIEF DESCRIPTION OF NIOSH FIELD STUDIES

Field research is the industrywide studies, surveys, and comprehensive analysis to determine the health status of the working population, including the incidence and prevalence of disease and injury; and studies to determine chronic and long-term effects of work-related exposures to toxic and hazardous substances. The following tables demonstrate the status of ongoing studies:

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases

(excluding agricultural industries)

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
Longshoremen 7/76	Physical activity	Cardiovascular and other diseases.	Existing medical data and employment files of International Longshoremen's Union.	7,000	Retrospective cohort study utilizing life table method to examine cause-specific mortality according to category of physical activity.	Exploratory research into possible association between on-the-job exposure and death from specific causes.	Final report due from contractor - possible extension of obtained additional data.
Aluminum refinery workers.* A 7/72 6/75	Bauxite/alumina, fluorides, coal tar pitch volatiles, carbon monoxide, sulfur dioxide, and other air contaminants.	Chronic respiratory disease, lung cancer.	A. Examination of currently employed workers utilizing X-rays, pulmonary function tests, and medical questionnaires.		A. Cross-sectional study of prevalence of pulmonary abnormalities.	A. Exploratory research into association between multiple exposure and prevalence of pulmonary abnormalities.	Final report due from contractor - results to be published.
B 7/72 6/75			B. Ten aluminum reduction plants.**		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	Results published as NIOSH technical report.
Copper smelter workers.* A 7/72 6/75	Sulfur dioxide, arsenic trioxide and metal fumes.	Non-malignant and malignant respiratory disease.	A. Examination of currently employed copper smelter workers utilizing X-rays, pulmonary function tests, sputum cytology and medical questionnaires.	1,000	A. Cross-sectional study of prevalence of pulmonary abnormalities according to sulfur dioxide and other contaminant exposure levels.	A. Exploratory research into association between chronic sulfur dioxide exposure levels and incidence of pulmonary abnormalities.	Final report being prepared for presentation at AIHA conference 6/75.

* Study conducted primarily for investigation of nonmalignant disease effects; however, carcinogenic effects also evaluated.
** Study completed in 1974.

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
B 7/72 6/75			B. Examination of copper smelter workers utilizing X-rays, pulmonary function tests and medical questionnaires.	400	B. Longitudinal study of incidence of pulmonary abnormalities.	B. Exploratory research into association between current sulfur dioxide levels and incidence of pulmonary abnormalities.	Contractor completed data collection and data analysis initiated.
Fibrous glass production workers.* A 7/72 12/75	Fibrous glass	Non-malignant and malignant respiratory disease.	A. Employment files of five fibrous glass plants.**	3,500	A. Retrospective cohort study utilizing life-table method to examine cause-specific mortality.	A. Evaluation of speculated association between fibrous glass exposure and malignant respiratory disease.	Results presented at NYAS Conference in Occupational Carcinogenesis and to be published in subsequent proceedings.
B 7/73 7/74			B. Examination of currently employed workers utilizing X-rays, pulmonary function tests and medical questionnaires.**	200	B. Cross-sectional study of prevalence of pulmonary abnormalities.	B. Determination of health status of fibrous glass workers and assessment of association between on-the-job exposure and disease manifestation.	Results not significant - internal report only.
C 7/72 10/74			C. Five fibrous glass manufacturing plants, four fibrous glass user plants and a reinforced plastics plants.**		C. Industrial hygiene and air sampling surveys.	C. Assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	Results to be published in "Environmental Research" - Spring 1975.

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
Cotton Workers I. Cotton Gin workers A & B 6/71 6/74	Cotton dust	Byssinosis and chronic lung disease.	A. Examination of currently employed cotton gin workers and matched controls utilizing X-rays, pulmonary function tests, and medical questionnaires.**	900	A. Cross-sectional study of prevalence of pulmonary abnormalities and incidence of these conditions in a sub-cohort of 300 individuals according to dust exposure levels.	A. Exploratory research into the association between on-the-job exposure and disease manifestations.	Internal Report - there are plans for publishing.
			B. Thirty cotton gins.**		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices, ani environmental controls.	
II. Mattress industry A & B 7/72 1/74	do.	do.	A. Medical survey of currently employed workers at two	50	A. Cross-sectional study of prevalence of pulmonary abnormalities.	A. Exploratory research into the association between on-the-job exposure and disease manifestations.	Results published as internal document and included in Cotton Dust Criteria Document.
			B. Above mentioned two mattress factories.		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases

(excluding agricultural industries)

3026E

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
III. Cotton textile workers 6/72 3/75	do.	do.	Employment files of two cotton textile companies.	10,000	Retrospective cohort study utilizing life-table method to examine cause-specific mortality.	Exploratory research into the association between on-the-job exposures and disease manifestation.	Final Report from contractor received - results to be published by mid-75.
Beryllium production workers.* A 7/70	Beryllium	Berylliosis and malignant respiratory disease.	A. Employment files of four beryllium production plants.	8,000	A. do	A. Evaluation of speculated association between beryllium exposure and lung cancer.	Final follow-up on cohort being delayed because of problems with obtaining records. Work progresses intermittently as time permits.
B 2/74 4/75			B. Two beryllium production plants.		B. Air sampling	B. Assessment of appropriate sampling methods.	Report from contractor will be published as NIOSH technical report in mid-75.
C 4/73 Continuous until 4/76			C. Beryllium case registry.		C. Investigation of causes of new beryllium disease.	C. Discovery of ill effects of previous unsuspected low levels of exposure.	Report submitted by contract at end of each contract year
Operating room personnel.* A 10/72	Halothane, nitrous oxide and other anesthetic agents.	A. Miscarriages, congenital anomalies, hepatic disease and malignancies.	A. Examination of currently employed operating room personnel and appropriate control groups utilizing questionnaires.**	82,000	A. Cross-sectional study of incidence of miscarriages, anomalies and malignancies in operating room personnel before and after venting waste anesthetics.	A. Exploratory research regarding expected decrease in disease associated with reduction in trace concentrations of anesthetics.	Results of operating room personnel survey published in ASA Journal 10/74 - Results of dental portion to be published in AOA Journal 7/75.

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

3026F

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
B 10/72 10/78 9/75			B. Examination of currently employed operating room personnel utilizing battery of psychometric tests.		B. Cross-sectional comparison of trace concentrations of anesthetics with alteration in psychological functions.	B. Exploratory research regarding expected association between exposure to trace concentrations of anesthetics and alteration in psychological functions.	Contractor in process of completing work.
C 10/73 10/75			C. Hospitals.		C. Industrial hygiene and air sampling.	C. Development and evaluation of procedures for controlling waste anesthetic gases and determination of feasibility of applying these procedures.	
Cosmetologists* A & B 6/72 10/74	Hair spray (PVP), hair dye (24TDA), and	Malignant and non-malignant respiratory diseases.	A. Examination of currently employed cosmetologists utilizing pulmonary function, X-ray, sputum cytology and medical questionnaires.**	800	A. Cross-sectional study of prevalence of pulmonary and cardiac abnormalities.	A. Determination of health status of cosmetologists and assessment of association between on-the-job exposures and disease manifestation.	Work Practices and Central Procedures developed under contract - Report to be published as NIOSH technical report 5/75. Second phase due 10/75 - Air Monitoring Program: Dental Offices - The three above will serve as a basis for criteria document due 4/76. Results presented in PhD dissertation and to be published in technical journal in mid-1975.
			B. Fifty beauty salons and cosmetology schools.**		B. Industrial hygiene and air sampling surveys.	B. Assessment of on-the-job exposures.	

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
Motor vehicle inspectors A & B 7/73 6/75	Carbon monoxide.	Cardiac disease.	A. Examination of currently employed motor vehicle inspectors using EKGs, DCG, and blood analysis.	500	A. Cross-sectional morbidity study of cardiac abnormalities.	A. Exploratory research to evaluate effect of long-term low level carbon monoxide exposure.	Final report being written.
			B. Thirty motor vehicle inspection stations.		B. Air sampling surveys.	B. Assessment of contaminant levels and worker exposures.	
C 7/73 11/75			C. Employment files of a state.	1,700	C. Retrospective cohort study utilizing life table method to examine cause-specific mortality.	C. Exploratory research into the association between on-the-job exposure and disease manifestations.	Final results to be presented at APHA in 11/75 and then published.
Chemical plant workers (e.g. coated fabrics, paint manufacturers) A & B 10/73 6/75	Solvents, plasticizers and other contaminants.	Peripheral neuropathy	A. Examination of current employees using neurologic examinations and EMGs, if appropriate, in nine industrial plants.		A. Cross-sectional medical study to determine prevalence of nerve disorders.	A. Exploratory research into the association between on-the-job exposures and disease manifestations.	Final report being written.
			B. Twelve industrial plants.		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
Mineral wool/slag wool production workers* A & B 7/74 12/76	Mineral wool/slag wool	Non-malignant and malignant respiratory disease.	A. Employment files of one mineral wool/slag wool plant.	3,000	A. Retrospective cohort study utilizing life-table method to examine cause-specific mortality.	A. Evaluation of speculated association between mineral wool/slag wool exposure and non-malignant and malignant respiratory disease.	Cohort identified - microfilming of records initiated. Walk-through surveys in 5 plants completed.
			B. Five mineral wool/slag wool plants.		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	
Bakery and confectionary workers 12/74 6/77	Dusts:Yeast and flour	Non-malignant respiratory disease and cardiovascular disease.	Examination of currently employed workers utilizing X-rays, pulmonary function tests, EKGs and medical questionnaires.		Cross-sectional study of prevalence of pulmonary and cardiac abnormalities.	Determination of health status of bakery and confectionary workers.	Problem identification and extent of problem being completed.

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

30261

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
			B. Granite shed and brick manufacturers.		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices and and environmental controls.	
Chrome plating workers 7/73 6/76	Chromic acid.	Mucous epithelial damage.	A. Five chrome plating plants.		A. Cross-sectional medical study of incidence of mucous epithelial damage.	A. Confirmation of previous indications of an excess risk and the quantification of that risk.	Industrial hygiene sampling completed. Medical Survey due to be completed 4/75.
			B. do.		B. Industrial hygiene and air sampling surveys.	B. Assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	
Clothing Workers* 1/74 1/75	Trichlorethylene, dusts, ultraviolet radiation, and other contaminants.	Unknown	Male apparel production plants.**		Identification and assessment of inplant contaminants, worker exposures, and work practices possibly leading to future mortality and morbidity studies.	Exploratory research into the association between on-the-job exposures and disease manifestations.	Final report in preparation - due 6/75 (characterization of industry only).

TABLE A --Industrywide epidemiological research studies of nonmalignant diseases (excluding agricultural industries)--Continued

Occupational Group (Begin End Date)	Suspect Agents	Biological Response Under Investigation	Source of Data	Number of Individuals In Study	Type of Study	Implications to Occupational Health	Status
Talc workers* A 7/74 6/76	Asbestos, silica, tremolite and other minerals.	Non-malignant and malignant respiratory disease.	A. Company personnel files.	800	A. Retrospective cohort study utilizing life-table method to examine cause-specific mortality.	A. Exploratory research into the association between on-the-job exposures and disease manifestations.	Personnel records being obtained from companies for mortality determination.
B & C 1/74 6/77			B. Examination of currently employed talc mine and mill workers utilizing X-rays, pulmonary function tests, sputum cytology and medical questionnaires.	800	B. Cross-sectional study of prevalence of pulmonary abnormalities.	B. Determination of health status of talc workers and assessment of association between on-the-job exposure and disease manifestation.	Contract awarded to Harvard for Vermont Study 7/74. Talc characterization initiated.
			C. Talc mines and mills and talc users.		C. Industrial hygiene and air sampling surveys.	C. Characterization of components of talc workers and assessment of inplant contaminant levels, worker exposures, work practices and environmental controls.	
Granite and brick industry workers. A & B 7/73 6/76	Silica	Non-malignant respiratory disease.	A. Examination of current brick workers utilizing X-ray, pulmonary function tests and medical questionnaires.	1,000	A. Cross-sectional medical study of pulmonary abnormalities to examine annual decrements in function at known exposure levels.	A. Confirmation of previous indications of an excess risk and the quantification of that risk.	Industrial hygiene sampling completed in Granite sheds for baseline data and 75% complete in Brick industry. Industrial Medical Survey procedures initiated 4/75.

Dr. SENCER. I think the ones that have attracted the most attention have been vinylchloride and cancer of the liver due to vinylchloride and the high potential of inorganic arsenics to cause carcinoma of the lung.

Mr. OBEY. Those terms really don't mean much to the average layman.

Can you take industry categories like steel workers, copper workers, asbestos workers, petrochemical workers? Can you name some of the everyday kinds of jobs where it is now possible that workers may be exposed to cancer causing agents in the work place?

Dr. SENCER. I could, if you would like, detail some of the studies that we have ongoing to develop this type of information. For example, in woodworkers, we are investigating the increased malignancies in the nose and throat to try and determine what the causative agent is in the wood dust.

In sheet metal workers we have been concerned about the fibrous glass particles in asbestos that may be related to pulmonary disease, cancer of the lung or other noncancerous diseases; the hard rock miners in the West, where they are exposed not only to silica, but also to radiation materials. They have had higher rates of not just the noncancerous lung diseases, but also cancer of the lung.

Mr. OBEY. What about uranium miners, grain handlers, steelworkers?

Dr. SENCER. Uranium miners, again we have had a study going for a good number of years. The concern there again is cancer of the lung. With people working in uranium mills we have been concerned about any increase of cancer in the lymph nodes and leukemia.

Mr. OBEY. I would appreciate it if you would put in the record a brief description of some of the studies that have been conducted not just by you but by others, some of the people who appeared in New York for instance, who stated what they thought they were finding. It is a matter of grave concern.

[The information follows:]

A brief description of studies described at the Conference on Occupational Carcinogenesis in New York March 24 - 27, 1975.

CRITERIA FOR CARCINOGENESIS by Emmanuel Farber, M.D., Ph.D., Fels Research Inst., Temple University, Sch. of Med., Philadelphia, Pa.

The induction of cancer by a chemical is a long process that involves the initial interaction of a chemically reactive moiety with many of the target cell constituents including DNA, RNA and protein. This initial phase may be very short, a matter of hours or days and is often irreversible. The subsequent development of cancer, a process often lasting months or years, and one subject to effective modulation by drugs, hormones, etc., is dominated by two important phenomena--cell injury and focal cell proliferation. The most attractive hypothesis views carcinogenesis as a process of cellular evolution eventuating in increasingly malignant cell populations. The imposition by the chemicals of appropriate selection pressures, such as by cytotoxicity, for the selective encouragement of altered putative premalignant cells, could be important. The carcinogenic chemical often triggers a chain reaction and need not be present during the whole process. Based on this view, carcinogenic activity may be monitored by concentrating on one or more of the suspected steps during carcinogensis. The events used most commonly for assay are the initial and the final ones. Some critical discussion of these and alternate ones will be presented.

RELATIONSHIP BETWEEN CARCINOGENESIS AND MUTAGENESIS by Joyce McCann and Bruce N. Ames, Dept. of Biochemistry, University of California, Berkeley, CA.,

The development of a bacterial test system for the detection of carcinogens and mutagens will be described. The test utilizes specially constructed mutants of Salmonella typhimurium for detection of mutagenic activity and rat (or human) liver microsomes for metabolic conversion of carcinogens to their active mutagenic forms. Chemicals are tested directly on petri plates with the bacterial tester strains and the microsomal activation system. The test is rapid and economical, and is proving extremely efficient in detecting carcinogens. Hundreds of compounds have been tested with our strains and about 75 percent of the carcinogens can be detected as mutagens and extremely few of the non-carcinogens are mutagenic. We have adapted the method for detection of mutagenic metabolites in urine. The test is being utilized in detecting potential mutagenic/carcinogenic activity of uncharacterized compounds in complex mixtures, and we have detected mutagenic activity in cigarette smoke condensates, and soot from city air. Recently, new tester strains containing resistance transfer factors have been developed which greatly extend the versatility and sensitivity of the test. A number of compounds of environmental importance, such as vinyl chloride and some metabolic products, can be detected in our system.

DOSE-RESPONSE RELATIONSHIP AND TRESHOLD CONCEPTS by Paul Kotin, M.D., Johns-Manville, Denver, Colorado.

Dose-response relationships and treshold (DRRT) are numerical expression of the effect of the reaction of an agent(s) with the chemical constituents of living organisms. In multicellular hosts a hierarchy of levels of reaction exists which can be categorized in several ways; anatomical--cellular protein to intact host; biochemical--transitory to persistent; functional--physiological to pathological; clinical--reversible to permanent; and teleological--good to bad. For noncarcinogens the concept of DRRT is universally recognized and has been quantified for many agents. The existence of DRRT for interaction of a carcinogen with the cell is controversial. The question of DRRT for a neoplasm as distinguished from a transformed cell is a critical one. The verification of DRRT for cancer production must include traditional pharmacologic criteria as well as additional factors such as repair mechanisms, the relationship of altered cells to the normal cell population in the host, latency, and the normal frequency distribution extant in heterogeneous populations. The biology of carcinogenesis and cancer induction appears to be compatible with DRRT.

ASBESTOS, SMOKING AND LARYNGEAL CARCINOMA.
By Robert W. Morgan, M.D., Department of Preventive Medicine, University of Toronto, and P. T. Shettigara, M.R.C.V.S., University of Toronto.

This study was designed to examine a previously reported relationship between asbestos exposure and laryngeal cancer. A retrospective case control study of 43 pairs of laryngeal cancer patients and their matched controls examined a number of variables, including smoking, asbestos exposure, and other occupational factors. Cases and controls were matched for age, sex and place of residence. The data indicate a highly significant association between asbestos exposure and laryngeal cancer. Cigarette smoking was also associated with the disease, although the strength of association was not as high as that for asbestos. Exposure to uranium, chromium, nickel, cobalt, arsenic, x-ray, and alcohol did not appear related to later development of carcinoma of the larynx. We therefore conclude that asbestos exposure and cigarette smoking are potent etiologic factors in the development of this disease.

CONJUGAL ASBESTOS NEOPLASTIC RISK
by H. Anderson, M.D., I.J. Selikoff, M.D., R. Lilis, M.D., S. Daum, M.D., A. Fischbein, M.D. and J. Churg, M.D., Mount Sinai School of Medicine, New York

As more industrial substances are found to have neoplastic potential, the risk of associated conjugal tumors should be evaluated. Numerous mesotheliomas among family members of asbestos workers have been reported. However, in the absence of well-defined population bases the actual incidence and extent of risk remains unknown. All the household contacts of 1,446 asbestos workers employed in a factory which produced amosite asbestos products from 1941 to 1954 are currently being traced and examined. Four cases of pleural mesothelioma have so far been discovered. Morbidity experience will be investigated for the cohort. Of the first 210 household members studied, 81 (38.6%) had radiologic evidence of asbestos exposure (pleural, parenchymal). The possible relationship of these changes to tumor induction in the future is presently unknown.

This study demonstrated that for one household substance, amosite asbestos, significant household contamination can and does commonly occur, and may result in characteristic radiological changes as well as in neoplastic disease.

RESPIRATORY DISEASE MORTALITY AMONG URANIUM MINERS by Victor E. Archer, M.D., J. Dean Gillam, M.A. and Joseph K. Wagoner, S.D. Hyg., Natl. Inst. for Occup. Saf. and Health, Salt Lake City, Utah.

A prospective repeat mortality study using a life table method was done on 3366 white and 780 nonwhite (mostly Navajo Indians) underground uranium miners, and about 1231 surface workers. Observed deaths were found to exceed those expected from the following causes among both white and Indian underground workers: respiratory cancer, pneumoconiosis and related diseases, tuberculosis, and violent deaths. Both respiratory cancer and pneumoconiosis related diseases exhibit a good exposure-response relationship when plotted against cumulative internal radiation exposure, mostly received from the alpha particles of radon daughters attached to inhaled dust particles. A high proportion of violent deaths were job related. Excesses of both malignant and pneumoconiotic types of respiratory disease were higher among cigaret smokers than nonsmokers, but the latent periods were longer among nonsmokers. Of three factors involved in both malignant and nonmalignant respiratory diseases (radiation, free silica, and cigaret smoking), radiation was considered to be most important. The data suggest that the present standard for Radon daughters (4 Working Level Months per year) probably gives adequate protection.

NEOPLASTIC RISK AMONG VINYL CHLORIDE POLYMERIZATION WORKERS by Richard J. Waxweiler, MSIE, William Stringer, MS, Henry Falk, M.D., Coleman Carter, M.D., James Jones, BSChE, Joseph K. Wagoner, S.D. Hyg., NIOSH, CDC

A retrospective cohort study of mortality among persons working at four separate polyvinyl chloride polymerization facilities was carried out. Study observations were limited to the period following five years of exposure and ten years since onset of exposure to vinyl chloride (VC). This restriction was imposed to avoid bias due to selection or due to insufficient latency for occupationally induced malignancies to become clinically manifest. An environmental profile indicated areas of VC exposure and the limitations of calculating individual estimated cumulative exposure to VC. Death certificates were obtained for all cohort members known to have died. Hospital records, pathology reports and tissues were collected, when

available, for review by an expert panel of pathologists to evaluate the primary site and specific histology of malignancies.

When mortality of the cohort was compared with U.S. white males, results demonstrated a close agreement with previous animal bioassay studies and human epidemiological studies in terms of excess risk of cancer and site distribution of those cancers.

ALDRIN AND DIELDRIN SUSPENSION BASED ON EXPERIMENTAL EVIDENCE AND EVALUATION OF SOCIETAL NEEDS. Samuel S. Epstein, M.D. Case Western Reserve University Medical School, Cleveland, Ohio.

The carcinogenicity of Dieldrin has been unequivocally demonstrated in valid independent studies on several strains of mice. While these data largely relate to hepatocarcinogenicity, inter alia as evidences by pulmonary metastases, other target organs are also clearly involved. Dieldrin is carcinogenic at the lowest dose, 0.1 ppm, tested. More limited studies demonstrate the carcinogenicity of Dieldrin in rats, in which multiple site tumors have been induced. No valid data exist on other species, including man. Dieldrin is poorly degradable and fat soluble and is widely disseminated as an environmental pollutant in air, water, food and human fat. Agricultural uses of Dieldrin have resulted in major economic losses, particularly to the poultry and fish industries. The major agricultural use of Dieldrin is as a prophylactic insecticide and no valid data support contentions for its efficacy sd used. Decisions to suspend major agricultural uses of Dieldrin reflect its carcinogenic hazards and the involuntary nature of human exposure, besides its lack of efficacy in a broad societal.

TOWARD AN INTEGRATED PROGRAM OF GOVERNMENTAL ACTION BY David P. Ball, M.D., Ph.D., Director, National Institute of Environmental Health Sciences: Chairman, DHEW Committee to Coordinate Toxicology and Related Programs, Research Triangle Park, North Carolina.

The elements of a rational program of governmental action on environmental carcinogenesis include: Information - Decision - Action - Followup. I shall concentrate on the first and last. The critical information needs are: What chemical--with what toxic effects (on laboratory animals or man) -- at what concentration is in contact with what population? The sources of this information include the private sector, the academic community and governmental laboratories. Before a governmental decision is made, it is critical that all information be collected and evaluated. The DHEW Committee to Coordinate Toxicology and Related Programs is in an excellent position to facilitate information collection, evaluation and dissemination from the academic and governmental sectors. Problems may exist in obtaining timely information from the private sector. Followup of a decision and the resulting action is important and has similar elements, emphasizing clinical and epidemiological studies.

PREVENTION OF OCCUPATIONAL CANCER - PROGRAM OF THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION by Donald V. Lassiter, Ph.D., Occupational Safety and Health Administration, Washington, D. C.

Prevention and control of occupational cancer involves an integrated program of regulatory exposure controls and effective educational and training programs. The Occupational Safety and Health Administration (OSHA) has program activities directed to each area. Of the 16 Health standards promulgated by OSHA following the "start up" standards, all have involved chemical substances with carcinogenic properties. Additional regulatory controls have been proposed for substances such as arsenic and benzene. Although mandatory exposure standards are necessary for prevention of occupational cancer, education of workers concerning cancer hazards is also necessary to enable workers to assess their risk of occupational cancer and to recognize exposure hazards in the workplace.

OSHA is working jointly with the Division of Cancer Control and Rehabilitation of the National Cancer Institue, the National Academy of Sciences, and the National Institute for Occupational Safety and Health (NIOSH) to develop an effective training and education program for workers concerning occupational cancer responsive to their particular needs.

INORGANIC ARSENIC: AMBIENT LEVEL APPROACH TO THE CONTROL OF OCCUPATIONAL CANCERIGENIC EXPOSURES by Hector P. Blejer, M.D., D.I.H., and William Wagner, M.S., National Institute for Occupational Safety and Health, Cincinnati, Ohio

In 1822 the first malignancies reported as due to arsenic exposure were scrotal cancers among smelters. A century later causal relationship between chronic occupational, environmental or medical arsenic exposure and skin cancer was firmly established. Since 1948 data from 9 epidemiological studies have, initially or upon review, demonstrated significant excess of lung cancer mortality among workers of diverse industries with exposure to various inorganic arsenic compounds. Two such studies reported in 1974 also showed significant excess of lymphatic system cancer and/or leukemia mortality. A semi-quantitative study demonstrated a dose-response relationship between arsenic and lung cancer, with a possible contributory role by sulfur dioxide and/or other contaminants; whereas the only quantitative epidemiological study, reported in 1974, revealed a dose-response demonstrating an increased lung cancer mortality risk at arsenic concentrations above 1 ug/M^3, calculated as the average occupational exposure over a 40-year work life. Given indications of increased cancer mortality resulting from community exposure to inorganic arsenic, and the absence of data documenting a safe occupational exposure, the conclusion is drawn that the arsenic body burden of workers should not be occupationally increased above that produced by the highest recorded ambient level.

LABORATORY APPROACHES TO THE IDENTIFICATION OF CARCINOGENS by Richard R. Bates, M.D., NCI Frederick Cancer Research Center, Fort Detrick, Frederick, Maryland

Occupational cancer results from failure to detect the carcinogenicity of chemicals before human exposure occurs. Chronic exposure of experimental animals is still the only definitive test for carcinogenicity, but high cost and long duration of these tests prevent testing more than a small proportion of environmental chemicals for carcinogenicity. Recommended improvements in bioassay protocols often lead to more definitive results for each chemical tested while decreasing the number of chemicals which can be tested on a limited budget. More consideration is needed of the optimum balance between test refinements and ability to test more chemicals. Short-term prescreening techniques being developed may permit more effective identification of carcinogens by increasing the proportion of them in enviromental chemicals selected for chronic animal bioassays. Approaches to prescreening include identification of electrophilic reactants among environmental chemicals and their metabolites, detection of reaction of chemicals with critical molecular targets in cells and their repair, mutagenesis prescreens, and cell culture transformation tests. Use of <u>in vitro</u> systems requires the development of effective metabolic activation systems to couple with the assays.

ONCOGENIC AND MUTAGENIC RISKS IN COMMUNITIES WITH POLYVINL CHLORIDE PRODUCTION FACILITIES by Peter F. Infante, DDS, Ohio Department of Health, Columbus, Ohio

The results of a preliminary investigation indicate that residents of the three Ohio communities with polyvinyl chloride production facilities gave birth to a significantly greater number of children with malformations during the period 1970-73, as compared to the expected, based on occurrence in the entire state. The rate of malformations in the index cities also was significantly greater than the rate in the balance of the counties in which these cities were located, $P < 0.001$. Other county-city combinations of similar size revealed no significant differences in malformation rates. Most notable among specific birth anomalies were those involving the Central Nervous System; 5.62 expected versus 17 observed. These preliminary findings do not link the presence of polyvinyl chloride production facilities with the increased occurrence of malformations, but indicate the need for further study of possible contributing factors.

CANCER AND CONGENITAL ANOMALIES ASSOCIATED WITH ANESTHETICS BY Thomas H. Corbett, M.D., University of Michigan Medical Center, Ann Arbor, Michigan

Survey studies have demonstrated a high incidence of cancer among anesthesia personnel and a high incidence of birth defects among their offspring. Teratogenicity of inhalation anesthetic agents in rodents has been demonstrated previously. Preliminary studies with isoflurane, an alpha-chloro ether inhalation anesthetic agent, suggest the agent is carcinogenic in Swiss/ICR mice. Groups of pregnant mice were exposed to subanesthetic concentrations by inhalation, and offspring further exposed every other day for 25 additional exposures. Controls were exposed to room air. Necropsies were performed at 3, 6, and 9 months of age. Pulmonary adenomas occurred with a higher incidence than in controls at all necropsy times. At 9 months, three liver neoplasms and one uterine malignancy were observed in experimental groups. These observations suggest the need to evaluate the possible carcinogenicity of all the halogenated alkane and ether inhalation anesthetic agents.

CANCER AMONG BENZOYL CHLORIDE MANUFACTURING WORKERS by Hiroyuki Sakabe, M.D., Hidetsuru Matsushita, Ph.D., and Shigezi Koshi, M.D., Natl. Inst. Ind. Health, Kawasaki, JAPAN

Three lung cancers (2 dead and 1 alive) and one maxillary malignant lymphoma were found in a small plant which had produced benzoyl chloride from 1954 to 1972. The number of employees had usually been 20. These four workers had engaged in the manufacture of benzoyl chloride in the very bad environmental conditions during 6 to 15 years before the onset of disease. Expected value of lung cancer death among benzoyl chloride manufacturing workers is 0.06 and observed 2 ($p=0.0017$). Benzoyl chloride was manufactured by hydrolysis of bensotrichloride which was prepared by chlorination of toluene. These victims had mainly been exposed to toluene, chloride, hydrogen chloride, benzotrichloride, and benzoyl chloride. Benzotrichloride and/or benzoyl chloride are suspected to be carcinogenic to humans considering that benzyl chloride which has a similar chemical structure to these was reported to be carcinogenic to rats.

VINYL CHLORIDE - BEST AVAILABLE TECHNOLOGY by Donald V. Lassiter, Ph.D., Occupational Safety and Health Administration, Washington D.C.

Promulgation of a standard regulating occupational exposure to vinyl chloride (VC) by OSHA on October 4, 1974, marked the initial Federal attempt to regulate occupational exposure to a carcinogen on the basis of available analytical methodology. Demonstration of carcinogenicity of VC had included experimental animal studies performed by separate investigators and a continuing case list of human cancer in workers occupationally exposed to VC. Although various tumors were observed both in experimental animals and in occupationally exposed workers, the fining of angiosarcoma of the liver in both instances revealed a definite correlation between chemical exposure and induction of cancer. The significance of polyvinyl chloride (PVC) production to the Nation's economy rendered impractical even de facto elimination of this important industry through unattainable controls prescribing "zero" employee exposure to VC. Rather, exposure to VC was limited to one ppm as an 8-hour TWA and 5 minutes as a 15-minute TWA. The one ppm exposure limited was based on recommendations made to OSHA by NIOSH and represented the sensitivity of available analytical methodology for determination of compliance.

THE FEDERAL ROLE IN PREVENTION OF OCCUPATIONAL CANCER IN MINES AND MILLS by James M. Day, Administrator, Mining Enforcement and Safety Administration, Washington, D. C.

The Mining Enforcement and Safety Administration (MESA) was established in 1973. Its establishment separated from the U. S. Bureau of Mines the administration of the Federal Metal and Nonmetallic Mine Safety Act of 1966, and, except for certain research functions, the Federal Coal Mine Health and Safety Act of 1969. MESA promotes health and safety in the minerals industry through inspection, investigation, and enforcement of Federal standards; technical support, education, training and motivation for State and industry personnel; sponsoring research in health and safety. Lung cancer is known to occur among miners exposed to airborne radiation in uranium and non-uranium mines, and among mill and mine workers with a history of exposure to asbestos. Mines and mills are being surveyed for inorganic arsenic, a possible carcenogen in the mineral industry. Health inspections are conducted on the basis of Federal standards designed to prevent the incidence of cancer. MESA's cooperation and exchange of information with other Federal and State agencies and private professional organizations will contribute to the prevention of occupational cancer.

CANCER MORTALITY AMONG WORKERS EXPOSED TO CUTTING OIL MIST by Pierre Decoufle, Sc.D., National Institute for Occupational Safety and Health, Rockville, Maryland.

Certain cutting oils have been found to be carcinogenic for the skin among exposed workers. The present study was initiated to determine whether exposure to cutting oils in the form of a mist increased the risk of malignancies of internal organs as well as chronic respiratory disease. Selected for study was a population of 5,189 production workers engaged in metal machining operations where soluble, non-soluble, and synthetic cutting fluids have been used for many years. They were employed between 1938 and 1967 and followed for mortality through 1967. Expected numbers of deaths by cause were computed based on U.S. white male death rates specific for age and calendar year. Total mortality for the group was less than the general population over the entire period of observation. Deaths from cancers of the respiratory and digestive systems were excessive only after 30 years from onset of exposure. When results were examined by duration of exposure and latency, systematic risk patterns were difficult to observe due to small numbers involved. Death rates for other major causes including non-malignant respiratory disease were lower than those predicted by the general population.

CANCER EXPERIENCE AMONG COKE BY-PRODUCT WORKERS by Carol K. Redmond, Sc.D., University of Pittsburgh, School of Public Health, Pittsburgh, Pa.

Previous reports on a study of 58,828 men employed in seven Allegheny County steel plants in 1953 show that men employed at the coke ovens in by-product coke plants experienced a high mortality from lung cancer, with the level of the lung cancer risk being directly related to the proximity of the workers to the coke ovens and the length of time employed at the coke ovens. Because of the exposure of the men in the by-product operations of the coke plant to a wide variety of coal tar distilletes, this updated report focuses on the cancer experience among workers in the coke plant as a whole, with particular emphasis on the mortality findings for non-oven workers. For all coke workers with 5 or more years experience in the coke plant, excesses in mortality due to lung cancers are seen in oven workers, with excesses in cancers of the kidney and prostate occurring in both oven and non-oven workers. Cancers of the digestive system are shown to be statistically significantly increased in non-oven workers. These observations clearly indicate the need to consider non-oven, as well as oven workers, in evaluating the cancer hazards in the coke plant.

36. CANCER MORTALITY AMONG RUBBER WORKERS, A. J. McMichael, D. A., Andjelkovic, H. A. Tyroler, Occupational Health Studies Group, University of North Carolina, Chapel Hill, N. C.

Several previous epidemiologic studies of the rubber industry--which uses many chemicals--have identified excess mortality from certain specific cancers. In this study, four cohorts of active (aged 40-plus) and retired workers, at four major rubber-tire plants, were identified historically, and followed for ten years. The cancer mortality of these four populations was compared, separately and combined, with that of the general community. For all cancers there was a slight excess above the expected number of deaths, while for some specific cancers (stomach, colo-rectal, prostate, and neoplasma of the lymphatic and hematopoietic system) there was a marked excess of deaths. Proportional mortality analysis at other, smaller plants revealed similar excesses for these cancers, and some excess for lung, bladder, and CNS cancers. Analysis of detailed individual work-histories reveals an association of certain cancers with specific job exposures--for example, leukemia and solvent exposure, lung cancer and curing room exposure, and stomach cancer and rubber processing. Further analytic studies are currently underway to identify groups of workers at increased risk of other specific cancers.

LEUKEMIA ASSOCIATED WITH BENZENE EXPOSURE by Enrico C. Vigliani, Clinica del Lavoro "L.Devoto", University of Milan, Italy.

Benzene has been known for more than a century as a bone marrow poison, leading to hyporegenerative or aplastic anemia. However, evidence has been accumulating in the last 40 years that benzene can also cause leukemias. More than 150 cases of benzene leukemia are known at present; in many cases, leukemia develops as a terminal stage of hyporegenerative anemia. It is mostly an acute hemocytoblastic or myeloblastic leukemia, sometimes leukopenic, but other types of leukemia are also said to occur after exposure to benzene. The experience of the Institutes of Occupational Health and Milano and Pavia are recorded, showing that more than 50% of the fatal cases of chronic benzene poisoning died of acute leukemia. There may be a latent period extending over several years between cessation of exposure to benzene, with more or less pronounced anemia, and the onset of leukemia. In the cases of anemia ending with acute leukemia, the anemic stage can be considered as a pre-leukemic one. Benzene is known to induce chromosomal aberrations and this might be an important factor in the pathogenesis of leukemia.

TYLER ASBESTOS WORKERS PROJECT, S. Donald Greenberg, M.D. The program was begun July 1974 in Tyler, Texas (Texas Chest Hospital) to investigate a cohort of 890 former asbestos workers. Approximately 90% of these men are cigarette smokers. Unique to the program are the sputum cytopathology studies (both aerosol induced and spontaneous early morming sputa specimens, each worker having sputum cytopathology every 6 mos. This report is based on initial study of 500 sputa specimens from 226 workers. 107 (47%) had no atyplas, 107 (57%) had mild atypias, 9 (5%) had severe atypias and 1 (.4%) had cells of a squamous carcinoma. 75 (32%) demonstrated ferrugenous bodies (FB) in their sputa. Only 2 (8%) had unsatisfactory specimens (saliva. The number of FB/specimen (4 Papanicolacu stained smears) were counted and reported as "few" (1-14), "moderae" (15-30), and "many" (30+). Of 75 w/FB, 43 (57%) had FB in aerosol specimens, 15 (20%) showed FB in spontaneous produced specimens, and 17 (23%) had FB present in both. The yield of FB in the aerosol induced specimens was almost twice that of the spontaneous specimens. The 19 specimens revealing severe atypias were equally distributed between aerosol induced and spontaneous sputa specimens. In the one patient whose sputa revealed squamous carcinoma cells, the chest roetgenogram showed no localizing lesions; however, fiberoptic bronchoscopy disclosed an ulcerative squamous carcinoma of the bronchius intermedius, proven by washing, brushing and biopsy. It is concluded that sputum cytopathology is an excellent, simple, noninvasive, painless and inexpensive means of early detection of malignant and premalignant lesions of the lung, and that no special techniques are necessary for the detection of FB.

SPUTUM CYTOLOGY AMONG ALUMINUM POTROOM WORKERS by David P. Discher, M.D., Bryce D. Brietenstein, M.D., and Abraham I. Schweid, M.D., University of Washington, Seattle, Washington.

In addition to a number of other parameters, the cytopathologic findings in sputum from a sample of aluminum potroom workers in the Pacific Northwest were compared with a group of matched controls. The results of this study were as follows:

Classification	Sample	Controls
Negative	0.58	0.63
Atypical	0.26	0.11
Suspicious	0.006	0.0
Positive	0.002	0.0
Unsatisfactory	0.12	0.21
Unknown	0.02	0.05

The morphologic findings were those typically seen in sputa ranging from regular mataplasia to outspoken squamous cancer. The meaning of the differences between the sample and controls remains doubtful.

CANCER MORTALITY PATTERNS ASSOCIATED WITH EXPOSURE TO METALS by Samuel Milham, Jr., M.D., Washington State Department of Health, Olympia, Washington

An age standardized proportionate mortality (PMR) analysis of the occupational and cause of death information on 300,000 white male death records filed in Washington State in the years 1950-1971, reveals an interesting neoplasia pattern in workers exposed to metals. The occupational groups studied were: boilermakers, copper smelter workers, machinists, metal molders, plumbers, structural metal workers, sheet metal workers, aluminum mill workers, welders, and tool and die makers. Eight of these 10 groups showed PMR increases for respiratory cancers. Four of the 10 groups showed PMR increases for cancer of the urinary bladder. Cancer of the tongue was increased in 3 groups, and cancers of the pancreas and malignant lymphomas were increased in each of 2 groups. Workers in aluminum mills showed PMR increases for cancer of the pancreas (PMR=204) and malignant lymphoma (PMR=250). The respiratory cancer increase seen in nearly all the groups suggests that metals (particles, fumes, etc.) are carcinogenic for humans when inhaled. The aluminum worker neoplasia pattern is different from that of the other groups studied here, suggesting that other agents may be responsible for the neoplasia.

CANCER MORTALITY PATTERNS IN THE LEAD INDUSTRY by W. Clark Cooper, M.D. Tabershaw/Cooper Associates, Inc. Berkeley, California

The mortality of 7032 men employed for one or more years in lead production facilities ("smelters") or battery plants was observed over a 23-year period, 1947-70. There were 1267 certified deaths. Lead absorption in many members of the cohort was known to have been greatly in excess of accepted standards. The standardized mortality ratio (SMR) for all causes was 107 for smelter workers and 99 for battery plant workers. Deaths from malignant neoplasms were somewhat elevated in both groups, the SMR being 133 for smelter workers and 111 for battery plants. The excesses arose largely from tumors of the digestive organs and the respiratory system. Only 3 deaths are attributed to malignant renal tumors and 7 to tumors of the central nervous system. The latter findings were of interest in view of the experimental production of renal tumors in rats and mice by the injection or oral administration of very large doese of lead salts, and the report by one group of investigators of gliomas in rats fed lead subacetate.

Studies are continuing to characterize more fully the exposures of the above lead workers to substances other than lead. Additional followup of the cohort is also contemplated.

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EARLY INDICES OF CANCER RISK AMONG URANIUM MINERS WITH REFERENCE TO MODIFYING FACTORS by Geno Saccomanno, M.D., Grand Junction, Colorado.

Periodic sputum examinations from uranium miners since 1957 have been studied to demonstrate the cytological development of epidermoid carcinoma of the lung. Many individuals developed atypical squamous cell metaplasia when exposed to cigarette smoke and radon daughter radiation, and many miners developed carcinoma in situ which eventually progressed to invasive carcinoma. Both of these carcinogens cause the premalignant squamous cell metaplasia of the lung when in concert, but the radon daughter carcinogen alone does not significantly add to the incidence of cancer among uranium miners, but cigarette smoking miners have at least a two-fold incidence of cancer of the lung, suggesting promotional or synergistic effect of these carcinogens. Age at start of mining was strongly associated with age of development of cancer of the lung. The period of time that elapsed in each stage of development of carcinoma in situ and the in-situ period varies markedly atypia; 2.94 yrs., marked atypia, and 4.45 yrs. in carcinoma in situ in a population of 34 cases followed through these stages of tumor development.

HOSPITAL ADMISSION RECORDS: A SOURCE FOR IDENTIFYING OCCUPATIONAL GROUPS AT RISK OF CANCER by Lorne Houten, Ph.D., Department of Biostatistics, Roswell Park Memorial Institute, Buffalo, N. Y.

In this study the Epidemiology schedules collected at Roswell Park Memorial Institute from 1956-1965 were analyzed for the relationship between occupation and cancer. The patients were subdivided by age, sex, diagnosis, occupation and industry, and length of exposure to occupation. Relative risks were calculated for the various categories described above using clerical workers as a control series. The full tables are to be published as a monograph by the National Institute for Occupational Safety and Health.

CANCER MORTALITY IN THE STEEL INDUSTRY by Edward P. Radford, M.D., Dept of Env. Med. Johns Hopkins Univ. School of Hygiene and Public Health, Baltimore, Maryland 21205.

Extensive studies of mortality by cause among steelworkers have been carried out over several years by Lloyd, Redmond and their coworkers at the University of Pittsburgh. Their results have indicated an excess of respiratory and genito-urinary cancer among coke oven workers; more detailed analysis by Redmond and Breslin indicates that janitors also show an excess of genito-urinary cancers. We have begun an evaluation of mortality of steelworkers at a plant not included in the above study. Results to date are from proportionate mortality only, but indicate that cancer deaths are in excess of those expected based on records for an adjacent urban area, especially for white workers. Principal sites contributing to the excess are respiratory cancer, bladder and kidney cancer, and pancreatic cancer. These excesses are not restricted to the coke oven operation. These preliminary results suggest that carcinogenic agents may be more prevalent in steel-making than has been previously supposed. Some differences between the two study populations which might account for these data will be discussed.

HISTOLOGIC TYPES OF BRONCHOGENIC CARCINOMA AMONG MEMBERS OF COPPER MINING AND SMELTING COMMUNITIES by John A. Newman, M.C., Victor E. Archer, M.D., Geno Saccomanno, M.D., Marvin Kuschner, M.D., Oscar Auerbach, M.D., Raymond D. Grondahl, M.D. and John C. Wilson, M. A.

An increased incidence of bronchogenic carcinoma is found among men and women of Butte, MT., a copper mining community. A significantly increased incidence of lung cancer is not noted in the residents of the counties of these cities. Comparison of histologic types of bronchogenic carcinoma shows a significant increase of poorly differentiated carcinomas among smelter workers. It is felt that this is due to exposure to arsenic. The miners and control group of "other" males show a histologic type distribution similar to other control groups and to asbestos workers. It is postulated that this may be due to exposure to certain silicates and amphiboles prevalent in the waste rock or gangue of the mines and the sanding, anti-skid material used on the Butte City streets. The histologic type distribution of Butte women is not similar to that of other report series, showing a high incidence of epidermoid carcinoma and a lowered incidence of adenocarcinoma.

THE IARC PROGRAMME TO EVALUATE THE CARCINOGENIC RISK OF CHEMICALS TO MAN by Lorenzo Tomatis, International Agency for Research on Cancer, Lyon, France

The International Agency for Research on Cancer has initiated a programme to evaluate the carcinogenic risk of chemicals to man. This programme is centered on the production of monographs on individual chemicals, consisting of data on use and production, carcinogenicity in experimental animals, epidemiological studies and case reports, and other biological data such as metabolism and mutagenicity, and ending with a balanced evaluation of all the data made by an international group of experts. Chemicals to be surveyed for the preparation of monographs have so far been selected among those for which some evidence or suspicion of carcinogenicity in experimental animals and/or man exists and for which human exposure is known to occur. Of the 196 compounds already evaluated, 17 have been found to be associated with cancer in man. Ninety-three compounds were definitely carcinogenic in experimental animals and 41 were shown to have a limited carcinogenic effect in experimental animals. A number of the chemicals found carcinogenic in experimental animals are produced in very large quantities. The type of exposure to the 17 chemicals found carcinogenic to man was occupational for 14, medicinal for two and dietary for one.

STATISTICAL EXTRAPOLATION METHODS FOR ESTIMATING RISKS FROM ANIMAL DATA by David G. Hoel, Ph.D., National Institute of Environmental Health Sciences, Research Triangle Park, N.C.

Regulatory standards for the permissible levels of environmental carcinogens often incorporate results from extrapolated animal carcinogenesis studies. Typically, data from a relatively high does experiment are first extrapolated to obtain a predict response at low does, which is then followed by the inclusion of a species conversion factor to give an estimate of the response in man. Various statistical models will be discussed with regard to their biological basis, or lack of, and their implications on prediction. Finally, some discussion will be given concerning the effects of experimental design on extrapolated values.

Mr. Obey. Let me ask, how much do you spend per coal miner, on occupational health research. Not that I want to downgrade the chairman's concern for coal miners, I respect it, but you have approximately 700,000 miners in the country.

Dr. Sencer. Do you mean just from NIOSH?

Mr. Obey. I mean for research.

Generally what is spent on research?

Dr. Sencer. Our budget for research and investigation in coal miners is roughly $4 million. Could I ask Mr. Baier for the universe?

Mr. Baier. It is about 100,000.

Mr. Obey. I had the impression that research being done for coal miners is much higher than that.

Mr. Baier. It is about $40 of research per person but if you include enforcement activities——

Mr. Obey. $40 of research.

Dr. Sencer. Per coal miner.

Mr. Obey. How much occupational health research per capita for all workers in the United States is being financed.

Mr. Baier. That would be the budget divided by 80 million.

Mr. Obey. Which is how much?

Mr. Baier. Roughly 30 cents.

Mr. Obey. That is an incredible difference—$40 research per coal miner but 30 cents research for all workers.

What would it take in your budget to spend $1 per worker for research on occupational diseases?

Dr. Sencer. $80 million. There are 80 million people covered under the Occupational Safety and Health Act.

Mr. Obey. $80 million, and you are spending $32 million. I wouldn't think $1 would be too much to spend for something like that. If we are spending $40 per coal miner. I recognize coal miners suffer dangerous diseases but I would think that if you are looking down the pike and if other workers, 10 or 15 years from now, had the organization and muscle which the coal miners had when the Coal Mine Health and Safety Act was passed—and I'm glad it did—but I think this country could be facing an incredible bill for reimbursement for all kinds of diseases.

I recognize it is much more difficult to say cancer is caused because the guy worked in a steel mill or he worked someplace else, but I think you have a potential problem there that would be horrendous. Am I crazy?

Dr. Sencer. I think you have to recognize much research that is going on is not labeled for occupational work, but will help us in that study.

Mr. Obey. You can say the same for any disease known to man.

Dr. Sencer. We are dealing in increased prevalence of disease in people who are occupationally exposed. As we get to know more about the causation of such diseases we can go into the work place to get it out. So work going on in the cancer institute may impinge on occupational health so I think there are other sources of funds for occupational health research.

Mr. OBEY. But the fact remains that 37 cents per worker is all you can directly point to.

Dr. SENCER. Yes.

If we were given $80 million tomorrow, I do not think we could use it well.

Mr. OBEY. I'm sure of that, but we sit here with no plans for a building, with no significant increase in the budget, a lousy $200,000 increase. Last year we were told by administration witnesses who testified that, "Well, this is such a huge area it is going to take forever and you cannot do anything very much anyway." It seems to me that is a reason to get off your tails and start doing something now.

I know it is not your fault. I want you to understand that, but I think the neglect in this whole area has been incredibly shortsighted and stupid.

I look at the CRS Library of Congress analysis of the Defense budget and all you see is "new initiative," "new initiative," all down the line.

I think it represents an incredible misplacement of priorities and damn bad judgment to continue to squeeze the budget for research on occupational disease. I for one want to make it clear that I think this committee has an obligation to give NIOSH every dime they asked for. If it doesn't, I will have an amendment on the floor.

I think this budget represents almost criminal negligence.

HAZARDS EVALUATION

Let me ask a couple of other questions on hazard evaluations. Are you running into some trouble with trade names?

Dr. SENCER. Yes, this has been a problem in the hazard assessment we did in the National Hazards Survey. The materials used in the workplace are trade named materials. Some people have been leary of giving us what is in the trade named materials but I think by now we have convinced everybody that we will maintain the confidentiality of the date. But now we find that one trade name leads back into another trade name and it has hampered the evaluation of what is in the workplace.

Mr. OBEY. What can be done to overcome that?

Dr. SENCER. I think this is part of the long-term problem of privacy and confidentiality that we face in Government.

I don't think there is an easy way to overcome that.

Mr. OBEY. Is there any change in the legislative authority that is needed here or what?

Dr. SENCER. I cannot tell you, Mr. Obey. My guess would be that this would open an awful bag of worms as you get into the whole area of trademarks, trade names, copyrights.

I think that is beyond us to respond to.

Mr. OBEY. You may have covered this. I have forgotten if you did when I was discussing criteria packages before.

What priority did you say you assigned vinylchloride?

Dr. SENCER. 206.

Mr. OBEY. How many other chemicals do you think it is reasonable to assume might have the same kind of surprises for us?

Dr. SENCER. If our best informed scientific thought was that vinyl-chloride would be that far down the line, I would not want to play statistics to come up with something like that. It does point out the need for increasing our surveillance and field studies so we can get on top of things like this.

Mr. OBEY. You think the No. 1 requirement is field studies?

Dr. SENCER. I think field studies and surveillance take the top priority of finding out what the new problems will be.

Mr. OBEY. Field studies budget this year was what?

Dr. SENCER. Three point four.

Mr. OBEY. In fiscal 1975?

Dr. SENCER. Yes, sir.

Mr. OBEY. NIOSH asked for what?

Dr. SENCER. In the 1976 forward plan, $7.4 million.

Mr. OBEY. You finally got how much?

Dr. SENCER. It will be about $5.2 million.

NIOSH HAZARDS SURVEY

Mr. OBEY. When will the National Occupational Hazards Survey be completed?

Dr. SENCER. The actual survey has been completed. The problem we are in is with the trademarks.

I am told it should be within a matter of the next few months, August.

Mr. OBEY. Will you explain for the record what that national survey is?

Dr. SENCER. Yes, sir.

[The information follows:]

THE NATIONAL OCCUPATIONAL HAZARD SURVEY

INTRODUCTION

The passage of the Occupational Safety and Health Act and the resultant increased emphasis on improving the industrial environment has accentuated the necessity for an efficient and effective approach to the identification of occupational health problems. A major deficiency in the past has been the lack of detailed information on a broad basis. The National Institute for Occupational Safety and Health (NIOSH) has instituted two major programs to alleviate this deficiency and provide data useful to many needs, from those of operating programs to those of congressional inquiries.

The first of these programs is the Illness and Injury Surveillance; the second is Hazard Surveillance.

The NIOSH solution to the information deficiency in Hazard Surveillance was implemented in February, 1972, and is called the National Occupational Hazard Survey (NOHS). Its completion in 1974 will yield results describing and quantifying worker exposures to chemical, physical, and biological agents in industry, thereby providing NIOSH with an overview of potential hazards to the American worker. Included in the survey results will be answers to such questions as:

1. How many workers are exposed to what substances?
2. In what work areas are these substances located? and
3. What means are used to alleviate their potential ill effects?

Answers to these questions will enable NIOSH to guide research activities into areas needing attention and, thus, avoid wasted research effort.

SURVEY DESIGN

The NOHS scope was designed to include all industries under the Occupational Safety and Health Act and virtually every potential hazard to a worker. This broad scope made special procedures necessary to avoid possible inconsistencies during data procurement. Furthermore, it required establishment of protocol for coding, editing, and analyzing the data after it was gathered.

To insure completeness, then, NIOSH broke the survey design down into three distinct phases, namely:

1. Selection of statistically representative facilities that could be surveyed in a reasonable time frame (two years);
2. Design of a system for collecting data, including design of a questionnaire, survey forms, and data procurement methodology; and
3. Design of a system to edit and analyze the data.

A. Sample Selection

Realizing that representative coverage of industry was imperative, NIOSH sought assistance on proper sample design from the Bureau of Labor Statisitics (BLS). The latter's access to a sampling framework and experience with other sample designs lent facility and credibility to establishment selection.

The BLS designed the NOHS sample based on covering the majority of U. S. workers over a minimum of establishments. Since the Survey was constrained to both a two-year time frame and a nominal staff, best estimates for a practical valid sample were from 5,000 to 6,000 establishments. In view of this limitation, BLS reduced the universe of candidates in the following manner:

1. Since establishments of less than eight employees work near cities, the Survey could be tailored to metropolitan areas; and
2. Since establishment of less than eight employees comprise 70 percent of industry but only 12 percent of the work force, a significant number of establishments could be eliminated from the sample universe without seriously affecting population coverage.

Using these simplifications, BLS specified a sample of 5,700 facilities located in 67 Standard Metropolitan Statistical Areas (SMSA's) throughout the United States. The nature of these facilities ranged from small shops to medium size retail stores to giant steel mills. Included with some of the country's preeminent corporations were the small family establishments. Hence, variety of size and industry were maintained consistent with the Nation's industrial profile.

B. Method of Gathering Information

The ultimate import of the NOHS depended mainly on the validity of the data and its applicability to NIOSH goals. Pertinent data procurement was, therefore, paramount in the survey design. Factors such as data collection logistics, ground rules, and level of hazard coverage figured significantly in the final mechanism. In view of these complexities, NIOSH took the following action:

1. Designed a questionnaire and recording approach consistent with the needs of occupational health personnel;
2. Developed a set of guidelines and Survey Manual around which to field train the engineers subsequent to the training course so that they would interpret recordable data homogeneously;
3. Constructed an initial "hazard list" for homogeneous coding of chemicals and physical agents; and
4. Took steps to hire 20 engineers and enroll them in a standardized industrial hygiene training program.

The collection of data was oriented toward direct contacts with the work environment. NIOSH planned that each engineer be assigned a geographical region and visit each of the sample facilities within that region. During a visit, the engineer would conduct an interview with management (using the standard questionnaire) pertaining to the health and safety policies of the company. Following this interview, he would tour the premises, concentrating on the number of workers, their occupations, and the chemical, physical (noise, vibration, etc.), or biological agents to which they were exposed. For example, if observing a group of painters, the engineer would record their occupation, how many workers he saw, and their specific exposures (butyl alcohol, noise, etc.). If trademark items (such as paints) precluded coding specific chemicals, he would record appropriate trade name and manufacturer so that further clarification would be possible. Along with chemical, physical, and biological agents, would be noted such parameters as the intensity (detectable or undetectable) and duration (full or part-time) of exposure, as well as the control used to avoid harmful contact (ventilation, protective clothing, etc.). Upon completing his tour, the engineer would return to his office, code the data on computer amenable forms, and submit them to the central office for editing and data reduction.

C. Data Processing

The design of a data handling system demanded accounting for and correcting raw data as well as coordinating several subsidiary aspects of data reduction. NIOSH anticipated that reports from the field would contain misspellings and items needing clarification. Therefore a combination of clerical skills, computer services, and contract arrangements was built into two processing procedures, namely:

1. A system of edits to sift anomolies from correct information. Errors in coding and inherent system errors made the edit system complex. Field data

forms contained several potential sources of error, including errors of omission, format, and spelling. The rigid requirements of final computerized data analysis demanded both clerical and automated editing for integrity of information. In addition, unexpected exposure records needed detection so that the original "hazard list" could be updated. The entire edit system was, therefore, designed to inspect and regiment all entries to prevent accumulations of unacceptable data.

2. A system of subsidiary clarifying mechanisms to refine the information. The data edits comprised only one part of the data processing procedures. NIOSH also needed to clarify inherent ambiguities in the raw data such as definitions of occupational groups and trade name exposures. NIOSH, therefore, acquired two clarifying mechanisms through contractural means. Occupational title classification was to be conducted by the Bureau of the Census, which was to use a standard three-digit occupational coding structure for cataloguing reported occupations. Clarification of trade names was the responsibility of a private contractor who would obtain ingredient information using mail-out requests to manufacturers.

SURVEY IMPLEMENTATION

With the completion of the NOHS design, NIOSH came to the most crucial and difficult part of the program--effecting an implementation and debugging procedure for the designed operations. Both field operations and data processing techniques needed smooth transition to congrue with the NOHS time schedule.

1. Field Operations

The selection of 20 field engineers for collecting data was divided into two phases. As part of the pilot study, NIOSH hired the first 10 engineers in September, 1971, and immediately sent them to a nine-week NIOSH sponsored training course at the University of Oklahoma. There they became familiar with the rudimentary aspects of industrial hygiene and the nature of industrial processes. Following classroom training, these engineers embarked on a two-month field training exercise conducted by the Pennsylvania State Department of Environmental Resources. Through actual plant visits with accomplished hygienists, they solidified their understanding of the industrial environment. Also during this period, the engineers familiarized themselves with the Survey Manual and helped finalize the Survey Guidelines for the purpose of future reporting homogeneity.

Actual survey field work began in February, 1972, in Baltimore, Maryland. From there, each of the engineers traveled to cities throughout the United States according to preassignments. Simultaneously, a second group of 10 engineers began training in a manner identical to their predecessors. By June, 1972, all 20 engineers were operating in pairs, functioning in their full capacity as NOHS field surveyors.

2. Statistical Modification

The progress of activities in the field soon made it apparent that the original sample was too large to finish by the target date, February 1974. Consequently, NIOSH, in consultation with BLS, modified the sample by statistically eliminating 500 of the remaining facilities. This step allowed field work to continue on a reasonable schedule and still maintained the Survey statistical integrity.

3. Data Processing

NIOSH completed NOHS field activities in June 1974. Additional effort is being devoted toward data clean-up, manipulation, and compilation. This process is intricate, and is requiring input from several sources requiring close coordination. Together with the data edits and corrections, NIOSH needed contributions from an industrial hygienist, a chemist, and a survey statistician.

This professional contribution helped resolve inconsistencies, reconciled discrepancies, and generally added refinement to the data. When the data was properly edited and refined, the process of extrapolating the results to represent the entire nation began. As part of this process, any statistical discrepancies were resolved and mathematical models describing the statistical variability were written. Special adjustments to the sampling scheme were needed to reconcile both explicit and implicit discrepancies in the sample. In addition, data from an inter-surveyor variability study were analyzed to evaluate data reporting consistency. Results from NOHS are scheduled to be available to the public in 1975.

Since the NOHS will involve information of varying interest, NIOSH will present the Survey results in two segments. First, it will publish a document highlighting the most useful information and describing the basis of the NOHS. In addition to this publication, NIOSH will construct a data retrieval system to answer further queries from agencies or interested parties. Information will be specific to a number of different parameters. Among these are:

1. Exposure frequency by occupational group;
2. Exposure frequency by standard industrial classification;
3. Occupational frequency by specific chemicals; and
4. Types of controls used for specific exposures.

NIOSH also will publish information from the subsidiary trade name ingredient clarification project in the form of a trade name index. The index will contain listings of all trade name products found in the course of facility site visits whose ingredients are not trade secret. Under each product name will be the name and approximate concentration of each ingredient present in amounts of one percent or more.

Laboratory Improvement

Mr. Obey. I have no other questions on NIOSH at this time. I do have one other question which is on laboratory improvement.

This committee gave you money for 40 positions last year. You are back here telling us this year that you never filled them.

Dr. Sencer. That is correct, sir. This is scheduled as a reprograming to meet the costs of the pay raise this past fiscal year.

Mr. Obey. So in other words, in spite of a directive in the committee report from this committee, a clear earmarking of those funds for that purpose because we thought it was important we are being told in effect, "Go to hell, your judgment doesn't count."

How else would you interpret it if you were in this chair or Mr. Natcher's or Mr. Stokes' chair? That is what we are being told to do, isn't it?

Mr. Miller. I guess in a sense you get another shot at it in that we have sent a reprograming letter to the committee asking to use those funds for the pay raise.

Mr. Obey. You do not expect the committee to say "Go ahead," do you?

Mr. Miller. I hope you would.

Mr. Obey. Well, Charlie, you know better than that.

Mr. Chairman, that is all the questions I have. I apologize for taking so much time.

Mr. Natcher. That is all right.

Lead-Based Paint Poisoning

Mr. Stokes. Dr. Sencer and gentlemen, I'm particularly concerned about the lead-based paint poisoning program, and also the rate control program and what appears to me to be some very serious cutbacks in terms of funding for these programs. Can I first ask you with reference to the lead-based paint poisoning program, what exactly does your program do?

Dr. Sencer. Our program is a program that provides financial grants to State and city health agencies to undertake the cost of screening children who live in environments where you could anticipate there is a high prevalence of buildings that have been painted in the past with lead-based paint.

Mr. Stokes. Does it consist solely of screening? Are there any preventive or therapeutic aspects?

Dr. Sencer. If no other method of funding is available, we have provided for therapy for children with abnormally high levels where they need therapy. Usually we can find local resources to actually take care of the inpatient management of children. We do report on dwelling units where we have demonstrated a lead hazard. We are authorized to do determinations of the lead content in the paint on the walls but we are specifically prevented from actually doing the abatement or paying for the abatement ourselves. We have been able to get some relief from that.

The chairman of this committee is very much concerned that the money not be spent on abatement and that this is a concern of housing agencies.

Mr. STOKES. You said you have conducted some treatment. Aren't many of these youngsters affected for life as a result of high lead content?

Dr. SENCER. If a child has a high level of lead in his blood, for prolonged periods, he will have neurologic and mental difficulties. So far we have found some 6,500 children with blood lead levels where it has been necessary to hospitalize the children for blood lead level. This is a process where the blood is pulled out of their tissues and excreted. We have an example of a child in one community who was brought out six times for treatment because he went back into the same environment and we could not get the hazard abated.

Mr. STOKES. To what degree does the Federal Government subsidize costs of that nature?

Dr. SENCER. In the treatment?

Mr. STOKES. Yes.

Dr. SENCER. In fiscal year 1974, $125,000 of project grant funds were used for treatment of the poisoned child. Most of these children are going to be eligible for medicaid and we are able to utilize funds such as that for the treatment.

We provide the outreach and screening and the local agencies find other methods of treatment.

Mr. STOKES. The majority of the lead-based paint poisoning cases are concentrated in the inner city; aren't they?

Dr. SENCER. Yes, sir. They are directly related to substandard housing.

Mr. STOKES. To what degree have we really surveyed that problem as it exists across the States?

Dr. SENCER. We have so far surveyed over one million children, 865,000 children up to this fiscal year.

We anticipate almost 500,000 will be screened during this fiscal year. We have grants in some 77 different communities and States.

I can supply a list for the record if you would like.

[The information follows:]

Lead-Based Paint Poisoning Screening Projects in Operation During FY 1975

Mobile County, Ala.

Arkansas

Contra Costa County, Calif.
Los Angeles, Calif.
Oakland-Alameda County, Calif.

Hartford, Conn.
New Britain, Conn.
New Haven, Conn.
Stanford, Conn.
Waterbury, Conn.

Delaware
District of Columbia

Savannah, Ga.

Chicago, Ill.
East St. Louis, Ill.
Peoria, Ill.
Rockford, Ill.
Springford, Ill.

Gary, Ind.

Burlington, Iowa
Des Moines, Iowa

Kansas City-Myandotte County, Kan.

Louisville-Jefferson County, Ky.

New Orleans, La.

Andrescoggin County, Lewiston, Me.
Medical Care Development, Inc.,
Augusta, Me.
Penquis Community Action Program
Bangor, Me.
Portland, Me.

Baltimore, Md.

Boston, Mass.
Cambridge, Mass.
Chelsea, Mass.

Community Teamwork, Inc., Lowell, Mass.
Citizens for Citizens, Fall River, Mass.
Lynn Community Health, Inc., Lynn, Mass.
Sommerville, Mass.
Waltham, Mass.
Worchester, Mass.

Detroit, Mich.
Wayne County, Mich.

St. Paul, Minn.

St. Louis, Mo.
Springfield, Mo.

Camden, N. J.
Hoboken, N. J.
Neward, N. J.
Patterson, N. J.
Plainfield, N. J.

New Mexico

Albany, N. Y.
Erie County, Buffalo, N. Y.
Monroe County, Rochester, N. Y.
Nassau County, Mineola, N. Y.
New York, N. Y.
Onondaga County, Syracuse, N. Y.
Rensselaer County, Troy, N. Y.
Westchester County, White Plains, N. Y.

Cincinnatti, Ohio
Cleveland, Ohio
East Cleveland, Ohio
Columbus, Ohio
Toledo, Ohio

Tulsa, Okla.

NE Pennsylvania Vector Control
Association, Pittston, Pa.
Allegheny County, Pa.
Chester, Pa.
Philadelphia, Pa.

Charleston, S. C.
Greenville, S. C.

Chattanooga, Tenn.
Memphis, Tenn.
Nashville, Tenn.

Houston, Texas

Norfolk, Va.
Richmond, Va.

Wisconsin
Milwaukee, Wisconsin

Mr. STOKES. I would appreciate that list. Let me ask you: From the testimony I have read here from you and Dr. Cooper and others, we have not been in this business very long; have we? Didn't we start in 1972?

Dr. SENCER. Yes, sir.

Mr. STOKES. Yes as a part of the rationale for now imposing more of an obligation upon the States, you mention that we have been in the business long enough. I do not quite understand that rationale.

Dr. SENCER. We have been able to demonstrate in just about every State in the Union the methodology of how this can be done. We have developed the competence in State public health laboratories to do the actual lead determinations. We have developed a new method. We should not take credit for the development of the method, but we have been able to get a new method of lead determination utilized across the country which has cut the costs of screening by almost a factor of 10. So it is our feeling that we have demonstrated how this can be done and it is up to local resources to continue the programs.

Mr. STOKES. In that vein, let me just cite some figures. In your testimony you say that since 1972, to screen 825,000 children of high risk, 70,000 of these had elevated blood lead and one-tenth had a blood level high enough to require therapy. Then in a report to this committee, and I quote from that report, you told us that there are an estimated 2.5 million children in the United States between the ages of 1 and 6 years in such housing, making reference, of course, to dilapidated houses that contained lead-based paint surfaces.

Of the children subjected to excessive lead absorption, many will suffer the serious sequela of lead poisoning, such as mental retardation or death. Control of childhood lead poisoning is based on identification and medical management of lead intoxicated children and the abatement of the lead-based paint hazard in their home environment.

In light of that, we see you request only $6,500,000 when we formerly appropriated $9 million to try to help you alleviate what appears to me to be a very tragic situation. I would like to have you elaborate for me upon the rationale upon which you operate.

Dr. SENCER. Could I correct the figure, sir? I think you are referring to the rescission budget there for the $6.5 million.

Actually, we are obligating the full appropriated funds of $9 million in fiscal 1975.

Mr. STOKES. If I am not mistaken, as I see your 1975 revised estimate, it is $6,507,000.

Dr. SENCER. I am quite sure that is the rescission budget.

Mr. MILLER. Our 1976 budget is $3,500,000.

Mr. STOKES. What is the request for 1976?

Dr. SENCER. $3.5 million.

Mr. STOKES. Then my statement is correct. Your 1976 request is $3,500,000, down from $9 million, is that correct?

Dr. SENCER. Yes, sir.

Mr. STOKES. Would you be kind enough to explain that to me?

Dr. SENCER. I think this goes back to the philosophy that these were to demonstrate the feasibility, develop the methodology adequately, to show it can be done but that it should not be a continuing Federal responsibility to fund the entire activity.

Mr. STOKES. Well, I guess this is really what disturbs me, because I am not sure local communities are capable of dealing with this kind of problem without the intervention of the Federal Government. Do you have some kind of a survey that shows you that our local communities are capable of being able to deal adequately with these kinds of funds?

Dr. SENCER. We do not have a survey of the financial capability but we feel the technical capability has been demonstrated to show it could be applied in any community.

Mr. STOKES. You say the technical capability. How does that gibe with the financial capability? Isn't it a matter of funds, a local community being able to pay for services of these kind and screen the children and abate the problem and apply medical therapy?

Dr. SENCER. We do have evidnece and we know that in 1974 the local communities contributed over one-third of all of the money going into lead-based paint poisoning programs. This was in a year when the actual Federal contribution was inflated because of carry-over money. So that in terms of a normal operating budget the State or local community would have been contributing 50 percent.

Mr. STOKES. If you now cut back, doesn't that require the local community to put in more?

Dr. SENCER. If this is one of their areas of priority, that they feel should be continued, yes.

Mr. STOKES. I would suppose that many local jurisdictions are in the same precise predicament that the city of Cleveland is in. I have here before me a letter from Mrs. Ruth R. Miller, a Ph. D. who is directress of the Department of Public Health and Welfare of the city of Cleveland. I would like to quote from that letter at this time, and Mr. Chairman, I would like permission to include the entire letter in the record.

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

[The information follows:]

City of Cleveland
RALPH J. PERK, MAYOR

DEPARTMENT OF PUBLIC HEALTH & WELFARE
RUTH R. MILLER, PH.D.
DIRECTOR

February 19, 1975

The Honorable Louis Stokes
Congressman
House Office Building
Washington, D. C. 20515

Dear Sir:

I appreciate the time you spent with me concerning the health problems of Cleveland and our collective concern relative to the means of solving these problems. We are certainly looking forward to working with you on a continuing basis for the betterment of our community.

As we discussed, the Cleveland Department of Public Health and Welfare has an immediate problem concerning the continuation funding of two of our federally funded programs, Childhood Lead Poison Prevention and Urban Rat Control.

These programs, federally administered by the Department of Health, Education and Welfare, Center for Disease Control, are scheduled for reduced federal funding this year. Because of our current local fiscal difficulties we cannot, this year, maintain these activities with any significant reduction in the federal level of support.

We are asking you to help us stabilize our federal funding at this year's level.

Both of these programs have had a significant, meaningful and long-range impact in Cleveland. For example, our Childhood Lead Poison Prevention Program tested some 10,000 Cleveland children, finding over 18% with elevated blood lead levels. Our Rat Control effort surveyed about 46,000 properties finding 12% of those properties with RAT signs and placing almost 18,000 pounds of bait on those properties. Additionally, there were 30 rat bites reported to us.

Again, we would appreciate any assistance you could lend us in stabilizing the funding of these important program efforts.

Sincerely,

Ruth R. Miller, Ph.D., Directress
Department of Public Health and Welfare

Mr. STOKES. What do I tell this very concerned and committed public servant who is apprising me as her Congressman of this serious and tragic situation in our city?

Dr. SENCER. I think it would have to be the same thing that all of the health services programs are facing at the present time, that we are cutting back in not just lead and rat control, but in VD, community health centers and others and it is the philosophy that many of these things are not Federal responsibility. The Federal Government has stimulated and provided startup costs, but then it becomes the responsibility of the State and local community to continue them.

Mr. STOKES. I guess that raises another question in my mind. When you say these are not Federal responsibilities, I suppose what you are talking about is the setting of priorities, isn't it? In terms of setting these kinds of priorities, where we say that this kind of health care is not really important, who makes these kinds of priorities for the administration?

Dr. SENCER. Mr. Miller.

Mr. MILLER. I would like to get into this issue a bit, Mr. Stokes.

I don't think it is a question of priorities. I think when Dr. Sencer says it is not a Federal responsibility, what he is saying, and what the budget is saying is that providing services in this area is literally not a Federal responsibility. There is no way the Federal Government is going to develop programs for lead-based paint poisoning or rat control that can cover the Nation. The best the Federal Government can do is demonstrate the best techniques for doing it.

If the program is going to cover the Nation, it will have to be picked up at the local level. We are never going to have service programs of that magnitude.

Mr. STOKES. If State and local governments are unable to finance the cost of these programs, then it is just their tough luck, right?

Dr. SENCER. Then you get to what you said, it is a matter of choice. There are just so many dollars to go around at any level of Government. I guess the Federal Government is saying that the States and localities will have to decide where their scarce dollars are going because the Federal dollar is even more scarce.

Mr. STOKES. Thank you. I have no further questions.

OCCUPATIONAL HEALTH

Mr. OBEY. I just wanted to read several statements into the record and I have a few more questions.

I would like to read several statements from NIOSH's "Forward Plan" to put squarely on the record what the position of NIOSH is on some of the questions we have been discussing.

One statement they made is that:

> The promotion of health care to prevent occupational and health problems, and to reduce the incidence and severity of injuries and diseases resulting from occupational hazards may be even more difficult in the near future as new technologies, substances, occupations emerge unless there is a concerted effort to foresee and forestall the future crisis by initiating appropriate action earlier.
>
> It is essential that several related initiatives be emphasized beginning in fiscal year 1976. These include an increasing occupational carcinogenesis program, a reinstatement of training grants, and an increased emphasis of research grants.

Then in regard to training grants, which was discussed somewhat, the plan says:

Emphasis in toxicology is particularly needed because of the numbers of chemical agents and combinations to which many workers are exposed.

Then they go on to say a page later:

A substantial increase in the budget and allocation to NIOSH for training grants to capable educational institutions would be a most effective means to begin to accomplish the needed training.

A page later:

The great need for increased number of personnel at the professional, technician or paraprofessional level suggests that substantial support for long-term training exists.

I wanted to get that in the record.

I also wanted to say, Dr. Sencer, that I was pleased to note in your statement at least a fair amount of discussion on occupational health problems.

I have great admiration for Dr. Cooper, but I was somewhat surprised yesterday that his statement contained no mention of occupational health. I also wanted to commend you for what I understand has been your effort to assist NIOSH with some of the personnel areas which are in, as you know, very short supply.

Dr. SENCER. You were saying you thought I was a good administrator. I want you to know we have very capable people in NIOSH. I think if you look at the output of everything including criteria documents, they have done a magnificent job.

LABORATORY IMPROVEMENT

Mr. MILLER. I don't think we have the record correct on the 40 positions. The way the situation is, the Congress added $700,000 for laboratory improvement. In our reprograming letter we are asking to use some $500,000 of that for the pay raise which leaves $200,000. That money is enough to fund the 40 positions in the fourth quarter. So our problem is not really with the reprograming. The issue is really within the executive branch. We have it before the OMB, and are discussing whether or not our ceiling will be increased so we can use the $200,000 for that purpose.

I don't want to misinform you. The money and the positions are not in the 1976 budget.

Mr. OBEY. I understand that.

That is all, Mr. Chairman.

Mr. FLOOD. Mr. Michel?

VENEREAL DISEASES

Mr. MICHEL. I note you are requesting a $5 million decrease in the venereal disease program. Where is this money being cut? Do you anticipate maintaining the program at current levels?

Dr. SENCER. Funds will be cut in all project areas, in proportion to their fiscal year 1975 funding level. With economies in control of program efforts and with the States assuming more of the program's costs, we expect to maintain program activities at the present level.

Mr. MICHEL. The materials you have submitted to us report a slight decrease in the number of cases of syphilis reported in 1974. To what do you attribute this decline? Do you anticipate that this downward trend will continue in the future?

Dr. SENCER. Infectious syphilis did decline very slightly in 1974, but early 1975 data show that we have returned to 1973 levels. Increasing levels of disease, however, appear to be localized. We believe we can deal effectively with syphilis in these situations and that we are entering an era of declining incidence.

SMALLPOX ERADICATION

Mr. MICHEL. The eradication of smallpox is certainly a tremendous accomplishment and is a great incentive for pursuing these kind of programs.

What has been CDC's role in international efforts to eradicate smallpox? What have we learned from this experience which can help us deal with other diseases that cross national boundaries?

Dr. SENCER. In 1966, the United States pledged its support to the World Health Organization's objective of a smallpox-free world by 1976. Since them, the Center for Disease Control has made significant contributions of on-site operational personnel, and has coordinated the major U.S. input of other technical assistance including vaccine, equipment, and supplies to the worldwide smallpox eradication effort. Through an agreement with USAID, the CDC represented the primary thrust of bilateral U.S. assistance to 20 West and Central African countries, some of which had the highest smallpox rates in the world. The success of the West African effort is widely recognized as reflecting one of the most effective programs of assistance ever carried out by the United States This area of Africa has been free of smallpox for 5 years.

The CDC has also provided over 100 short-term consultants to WHO to assist Bangladesh, Ethiopia, and India's eradication programs and will continue to furnish similar epidemiologic and management expertise to this remaining stronghold of smallpox until eradication of this disease has been achieved.

The smallpox eradication program has demonstrated that countries of widely diverse physical, cultural, and political differences can work effectively together to achieve goals of mutual interest. As evidence of this, in many instances health teams of one country were authorized to cross the border of another to adequately manage an outbreak and halt the spread of disease which recognized no ethnic or political boundaries.

One of the more encouraging outcomes of the smallpox eradication program has been the recognized effectiveness and increased use in developing areas of the paramedic in preventive health programs. The acceptance of this concept has enabled physicians who are in critical supply in developing areas to be more effectively used.

A direct benefit to the United States, once smallpox eradication has been achieved, will be the savings of approximately $150 million a year which the United States was spending to prevent the importation of smallpox into this country.

Mr. MICHEL. I was fascinated by your prediction that smallpox would be eliminated from India in the next few weeks. How can you be so precise?

Dr. SENCER. My prediction of smallpox eradication in India within the next few weeks is based on the continuing dramatic decline of outbreaks in India and the demonstrated surveillance and contain-

ment capability of WHO and India's staff in the infected states. At the present time, there are only 39 outbreaks identified in all of India in spite of intensive village-by-village searches.

Mr. MICHEL. I remember reading some time ago that one of the reasons it has been possible to eliminate smallpox was the fact that it was wholly transmittable by humans and there were no other carriers. So animals, clothing, and other objects could not transmit the disease and therefore when it was no longer infecting people it would be totally eradicated.

What other communicable disease would fall into a similar category and could conceivably be wiped out some day? For instance, wouldn't VD generally fall into this kind of area though eradication is obviously a long way off?

Dr. SENCER. Generally speaking, yes. However, a major factor in smallpox eradication is a vaccine and we have no such advantage in venereal disease control. Because of the relatively long incubation period for syphilis, early treatment of exposed individuals serves to prevent the development of clinical disease and to curtail disease transmission. However, a treated person has no protection against reinfection if he is reexposed to the disease.

Mr. MICHEL. How do we know that any disease like smallpox is, in fact, eradicated?

Dr. SENCER. Once the interruption of smallpox transmission has been achieved within a country, that country must withstand intensive surveillance over a period of 2 smallpox-free years; and then a comprehensive terminal assessment by a committee of smallpox and epidemiologic experts before smallpox eradication in that particular country can be confirmed.

Mr. MICHEL. Could there be unreported cases in some of the less developed areas of the world?

Dr. SENCER. While it is possible that in some remote areas pockets of smallpox could continue for a short time, it is not likely that the death or scarring of smallpox victims would remain undetected for long during a period of active searches to detect cases.

Mr. MICHEL. It is rather frightening to think of the disease reappearing among a population which is no longer vaccinated and thus would be unprotected and ripe for an epidemic. How can we be sure that smallpox vaccinations are no longer necessary?

Dr. SENCER. The concept of mass immunity to protect a population is misleading when it comes to smallpox because smallpox vaccination affords complete protection for only 3–5 years. Any country, including the United States, would have to have universal vaccination and then continuing revaccination every few years to maintain protective levels of population immunity. Smallpox-free countries enjoy that status because smallpox has either not been imported into the country or when it has the containment response capability has effectively managed the outbreak.

In West Europe, a study of smallpox importations over the past two decades has shown that control measures are applied and are generally the same regardless of past immunization programs or known levels of high or low smallpox immunity within the respective populations.

Smallpox vaccinations are no longer necessary except for travelers to smallpox-infected areas. Once worldwide smallpox eradication has been achieved, vaccination against smallpox for all practical purposes can be immediately terminated.

Polio

Mr. Michel. I was rather interested in the fact that only 5 cases of paralytic polio were reported in the United States last year. How does this compare with the incidence of polio in other parts of the world?

Dr. Sencer. Generally, the most recent polio data available in the World Health Organization's statistical summaries is for 1972.

During that year when the United States had 31 cases, a total of 8,838 cases were reported to the WHO throughout the world. For comparison, reported cases by continent are:

Africa	1,597
Americas	3,169
Asia	3,762
Europe	302
Oceania	8

No reports were received from Russia and China.

Mr. Michel. In view of the upswing in polio immunization and the overwhelming decline in the number of cases of this disease, what are the chances of totally eliminating this disease from this country and the entire world?

Dr. Sencer. Widespread administration of oral polio vaccine throughout the world would produce the same dramatic decline in polio cases as we have experienced in this country. However, we do not know what would be required to completely eliminate polio virus infection from the world. We know that polio transmission can occur in the absence of clinically manifest illness. We can, for example, recover poliovirus from community sewage in the absence of any sign of polio-like illness in the community. To know what would be required to truly eliminate polio virus infection from the world requires a better understanding of the epidemiology of the disease than we now have. In terms of requirements for eradication, we understand the epidemiology of smallpox much more clearly than that of poliomyelitis.

Rat Control

Mr. Michel. The decline in rat infestations in target areas served by rat control project grants is encouraging. Can this success be duplicated in other communities? What are the critical factors in establishing and maintaining control over rat infestations?

Dr. Sencer. Yes! The basic factors necessary to all urban rat control programs are fundamentally the same despite the fact that cities do vary considerably in their environmental problems and governmental infrastructure.

The critical factors are the commitment to rat control on the part of local officials, and the involvement of citizens in carrying out a program. Municipal services and code enforcement must be highly responsive and coordinated, and the residents in rat infested areas must be

actively involved in carrying out the program. Currently, approximately 66 percent of the persons employed through rat control grants are residents of target areas.

Lead-Based Paint Poisoning Prevention

Mr. Michel. Lead-based paint poisoning prevention grants can be made only to a limited number of communities. What actions, if any, has the Center for Disease Control taken to see that children in other communities who may suffer from lead-based paint poisoning are also diagnosed and treated?

Dr. Sencer. We have put major emphasis on helping States develop laboratory capabilities to facilitate screening throughout the State. The lack of adequate laboratory facilities has been a major roadblock to screening under Medicaid and through other State or locally sponsored programs. We also provide technical assistance to State and local agencies in designing and carrying out lead screening programs.

Mr. Michel. Has the incidence of lead-based paint poisoning gone down any since the inception of the program?

Dr. Sencer. In fiscal year 1973, the first year of the program, 72 children were found to have elevated blood lead levels of every 1,000 who were tested. This relatively high level was expected due to the increased awareness of the communities and the increased screening activities. During the second year of the program, there was an unexplained decrease in the number of children determined to have a lead problem. In the first 6 months of fiscal year 1975, reporting again reached a high level with 74 children out of every 1,000 tested showing increased lead absorption. Some of the older programs are experiencing a decrease in the percentage of children tested who are found to have elevated blood lead levels. We are receiving reports that there is a marked decline in the number of children seen in hospital emergncy rooms with acute lead poisoning, but we do not yet have any firm data.

Mr. Michel. Do you have any data on the State or local efforts to establish regulations and criteria with regard to building codes and other administrative procedures which would eliminate the hazard potential before it created problems? Do you encourage this sort of activity?

Dr. Sencer. The Center does not have complete information on building codes or administrative procedures which would eliminate the hazard potential before it created problems. We do have on file, copies of ordinances or regulations from 36 local communities and States which have been enacted to control the applications of lead-based paint and require its removal when a child has ingested such paint in his dwelling.

Most communities have ordinances which provide for the removal of general health hazards and nuisances. Flaking paint and toxic substances such as lead are, therefore, covered by these codes. Communities can use these to require the removal of lead paint. However, because of the magnitude of the lead-based paint problem, we have opted to seek out those children who are actually ingesting lead paint, and to give priority to corrective action in their environment.

Occupational Carcinogenesis

Mr. Michel. I note that you anticipate your carcinogen research will cost nearly $1.3 million. How does this research tie in with the research done at NIH? How do you coordinate these efforts?

Dr. Sencer. There is no overlap of the NIOSH carcinogenesis program with the programs of NIH. NIOSH's program includes epidemiologic and occupational health surveys of the workers handling carcinogens or substances suspected of having carcinogenic activity and studies of the concentrations found in the occupational environment. A major responsibility of the several activities of NIH is in the area of experimental carcinogenesis research in laboratory animals. A proposed NIOSH study on the effects on rats exposed to vinyl chloride has been coordinated very closely with researchers at NIH.

Coordination of these activities occurs at several levels; the formal liaison through the DHEW Committee to coordinate toxicology and related topics, interagency collaborative group for environmental carcinogenesis, interagency collaborative group for environmental mutagenesis, and the several ad hoc subcommittees, and informally through personal contact between individuals of the several organizations.

Mr. Michel. Thank you.

Mr. Flood. Mr. Conte?

Smallpox Eradication

Mr. Conte. Dr. Sencer, I would like to commend you and your organization for whatever role you had in the cooperative international effort to eradicate smallpox. Would you explain why it is no longer necessary to vaccinate all children for smallpox?

Dr. Sencer. For the vast majority of people in the United States, the probability of experiencing serious complications from vaccination is much greater than the probality of contracting smallpox. There has not been a confirmed case of smallpox in the United States for more than 25 years and because of the success of the global smallpox eradication program, the risk of smallpox importation into the United States is approaching zero.

Mr. Conte. How do you decide which children should be vaccinated and which should not be?

Dr. Sencer. Vaccination of children should be required only of those considered at special risk because they are traveling to and from smallpox infected areas.

Tropical Diseases

Mr. Conte. Would you like to describe some of the efforts currently underway to control malaria and parasitic and diarrheal diseases in the developing countries?

Dr. Sencer. The diseases specified, malaria and parasitic and diarrheal diseases, constitute the principal health problems in the developing countries and impose a burden that is almost incalculable, both economically and in terms of human suffering. To quote a few recent worldwide estimates on the prevalence of some of these diseases: Malaria—500 million cases; schistosomiasis—300 million; filariasis—

250 million; onchocerciasis—20 million; African trypanosomiasis—50 million; American trypanosomiasis—50 million; intestinal helminths—1,000 million. The bacterial and amebic dysenteries similarly affect vast numbers of people in developing areas. Many of these diseases have their greatest effect on infants and children. Essentially they are diseases of the warm climates, where the very large majority of developing nations are located, although in most cases the more temperate regions such as the United States would be receptive to their introduction or reintroduction.

These diseases are also characteristically difficult to control, particularly in areas where the economy will not allow for proper sanitation and other public health measures. For many of these diseases there are not at present fully satisfactory therapeutic drugs—only for malaria and for some of the parasitic and bacterial infections of the intestinal tract are there reasonably good drugs, and even here there are still problems. For none of the parasitic diseases, including malaria, are there immunizations available, and none can be foreseen for the near future.

In the face of these difficulties, many of the developing countries have a full recognition of the problems and have been and are mounting efforts to decrease this burden of disease. An example of this is the effort toward the worldwide reduction of malaria. In the mid-1950's, encouraged by the availability of DDT and by successes in a few areas, a worldwide campaign to eradicate malaria was mounted under the leadership of the World Health Organization. For a variety of reasons, this campaign has fallen short of its goal, and a revised strategy is now directed toward retaining the gains and a continuing effort toward slow reduction of malaria everywhere. There have been setbacks and malaria is increasing in some areas where early successes had been achieved, but today there are hundreds of millions of people living in areas where malaria no longer exists or is now only a minor problem. Most countries in the Western Hemisphere where malaria is still a problem are maintaining control or eradication programs consistent with their ability to support this activity and within the limitations of the available technology.

Another example of a unified effort toward the control of a decimating disease is the recently initiated onchocerciasis control program in the Volta Basin area of West Africa. Through the efforts and support of international agencies and of the countries involved, there will be a long-term effort to control the disease transmitting blackflies in the rivers and streams of the areas through the judicious use of insecticides. This will require a commitment of resources for perhaps as long as 20 years, but if it succeeds in the elimination of this blinding disease, it will indeed be an accomplishment of heroic proportions.

Discussions are currently underway on the possible mounting of a multinational program for the control of schistosomiasis, the ancient and debilitating disease transmitted through snails and affecting millions in Asia, Africa, South America, and the Caribbean. The development of water resources for irrigation, energy, and other uses in many of the developing countries threatens to provide new and favorable habitats for the snail vector, thereby increasing the threat and the range of human infection. The program being considered would at-

tempt to "build out" favorable snail habitats or to otherwise facilitate their control in newly constructed water collections. Meanwhile, limited control programs continue in afflicted countries, probably without significant reduction in population risk in most areas. There has been a recent demonstration in Saint Lucia on the reduction of schistosomiasis simply by the provision of piped water supplies, obviating the necessity for using snail-infested water collections for the multiple needs of man. There are reports that the People's Republic of China has been highly successful in controlling the disease, principally through intensive efforts toward elementary sanitation.

Control of filariasis depends on mosquito control, and there are continuing efforts in a number of areas to reduce the transmission of this parasite, both by traditional methods of mosquito control and by exploration of newer genetic methods. African trypanosomiasis still poses an enormous problem for that region, and there is little new to report in efforts to control this disease.

The intestinal infections, both parasitic and bacterial, are basically related to sanitation and will only be reduced significantly when economic development is sufficient to improve sanitation or when improved technology of control or treatment becomes available. Most countries maintain programs for case finding and treatment. While such programs may reduce mortality and morbidity to some extent, they have little impact on the prevalence of these infections. A child treated successfully for a worm infection can regain an equally heavy infection in his unsanitary surroundings within a few weeks. Efforts are also made in most countries to improve water supplies and waste disposal, but the difficulties of economic and social underdevelopment make progress very slow.

It is obvious that the continuation of these diseases in developing countries is closely related to their economic problems, but is also related to some extent to an underdeveloped technology for their control and treatment. It has been pointed out that of all the money spent on biomedical research in the world only 1 percent is specifically devoted to the major disease problems of the developing countries.

One major consideration which should not be overlooked is that these disease problems are often accompanied by malnutrition, which both intensifies and in turn is intensified by disease. The breaking of this vicious cycle of disease and malnutrition will depend on slow progress toward reduction of disease conditions which debilitate populations, thereby increasing economic capacity, which in turn will make possible better nutrition and a population better able to contend with their parasites.

Mr. CONTE. What is the role, if any, of the American Public Health Service in these efforts?

Dr. SENCER. The PHS can contribute significantly to the solution of some of these problems through direct field and laboratory studies and through consultation and cooperation with countries, international organizations and other U.S. agencies who have mutual interests in their solution. Thus CDC maintains an extremely valuable medical and scientific capability that is a necessary national resource for our own health protection. Some of the greatest needs for basic information and control methodology include: the development of satisfactory immunization procedures; this may be a long way in the future for the

parasitic diseases but probably has a chance for early success in some of the bacterial dysentery diseases; the development of laboratory models for study of some of the major parasitic diseases without which studies on treatment and immunity cannot proceed; the development of new chemical insecticides and methods for their application which will not produce environmental hazards of consequence; the development of better methods of surveillance and diagnosis of disease in developing areas; the evaluation of prophylactic and therapeutic treatment procedures for parasitic diseases; and the investigation of new and old naturalistic methods for the control of disease vectors, including genetic methods, source reduction by engineering methods, and use of natural enemies of vector species.

The Public Health Service has a role in supporting efforts toward control of diseases in developing countries, not so much in direct assistance in control programs but in development and evaluation of the technology of control methods. The mounting of successful control programs has often been hampered by either the lack of a good method or by the failure of known methods. Frequently, the primary cause of failure has been an absence of sufficient knowledge of a disease in its natural habitat or of the habits and habitats of the mosquito or other insect vectors. One example is the failure to control malaria in some areas because of variations in mosquito behavior. Not all species of malaria-carrying mosquitoes act alike: for example, some prefer to bite and rest indoors and others out of doors. While spraying the inside of a house with insecticide may be effective for the former, the futility of spraying indoors to control transmission by outside biters is obvious. This and many other examples point out the need for thorough knowledge of disease transmission systems. Because mosquito-transmitted disease is of importance in the United States, studies on control measures for these vectors can be widely applicable. These efforts include the development and evaluation of new and existing environmentally acceptable chemical insecticides and methods for their application, exploration of nonchemical control measures such as the use of the sterile-male release method, studies of natural enemies and diseases of mosquito population, and others. Several examples of the contributions of the PHS in this field might be cited. The ultra-low-volume application of insecticide, a method which is environmentally sound, has been adequately evaluated for the first time for actual disease control in an area of Haiti. Here the control of the malaria mosquito and malaria transmission had been particularly difficult, and through this carefully planned and executed study the ULV method was shown to be effective. This method can now be used with confidence elsewhere under similar circumstances. The potential effectiveness of another method of controlling the malaria mosquito, that of vector population reduction through the release of sterile male anophelines into the natural populations, has been demonstrated in El Salvador through a joint PHS–U.S. Department of Agriculture program. This method is also characterized by having no undesirable environmental impact. Further studies are being done in a highly malarious area to define the extent to which this may be a practical method of malaria control. Additionally, the PHS provides on a continuing basis cooperation with the international organizations through consultation on the many problems of malaria control.

During the past 4 years the PHS, CDC has cosponsored international symposia, one in El Salvador and one in Morocco, on the problems of malaria control and needed research in the developing countries of their respective regions.

Another example of a supportive role of the PHS is in cooperative participation in the onchocerciasis control program now underway in Africa. This program relies entirely on the killing of the blackflies through the use of chemical insecticides. At the request of the World Health Organization, assistance is being provided by PHS experts in devising appropriate formulations for insecticide application and analytical methods for determining insecticide residues in the environment to insure that hazards to nontarget organisms, including man, are within acceptable limits, while at the same time insuring that the applications are effective against the target insect.

Another role of PHS lies in provision of training for medical and scientific personnel from developing countries in disciplines which are essential to the progress of disease control programs in these areas. This training may consist of formal training courses, but is often on a 1-to-1 basis, making possible the advancement of the student in a particular technology through consultation with a professional counterpart in the United States. Such associations not only provide benefit to the visitor but also are informative to the U.S. counterpart as to the practical problems of field application of control measures and often provide a link between basic and applied research on disease control methodology which can benefit control programs in the United States as well as in the developing countries.

Immunization

Mr. Conte. How many cases of measles, rubella, and diptheria were there in this country last year?

Dr. Sencer. In 1974, 22,085 cases of measles, 11,836 cases of rubella, and 257 cases of diphtheria were reported in the United States. This represents the fewest number of cases of rubella and measles ever reported.

Mr. Conte. What is currently being done, and provided in this budget, to eradicate them completely?

Dr. Sencer. Since 1963, project grants have supplemented State and local immunization programs. These grants were primarily directed toward intensive efforts to reduce backlogs of unimmunized susceptible children. Now that reported cases of diseases have declined, States and communities will provide funding for an increasing share of ongoing immunization activities. Project grant support will be targeted to high-risk populations and support intensive disease surveillance, assessment of immunity levels to identify subpopulations at greatest risk, and rapid outbreak control activities when disease does occur.

Venereal Diseases

Mr. Conte. To what do you attribute the increase in infectious syphilis?

Dr. Sencer. The increases in infectious syphilis have been geographically localized, and we feel we can deal with this situation effectively. Another very important contributing factor has been an

increase in reported cases among male homosexuals. We believe this is a reflection of our ability to work effectively with this group, rather than an actual increase in either homosexuality or homosexual disease transmission. Many health departments throughout the country have been extremely active in removing the many barriers which have mitigated against cooperation between health care providers and this segment of the population.

Mr. CONTE. Doesn't this increase indicate a need for the direction of greater efforts into this area? Can this be done under the budget you are presenting?

Dr. SENCER. All program activities should be maintained at current levels, although we are calling on State and local governments to increase their share of funding for the program.

Mr. CONTE. Last year there was some mention made before this committee about the need for more screening of males for asymptomatic gonorrhea. What has been done in this area during the past year, and with what results?

Dr. SENCER. During fiscal 1975 in five project areas, we began interviewing female gonorrhea patients for their male sexual partners. In the past 7 months, we found that more than 18 percent of these male contacts were asymptomatically infected. However, routine screening of males within the general population has proven unproductive. We are, therefore, encouraging grantees to begin interviewing female patients to the extent that resources permit, but are not recommending routine screening of males.

Mr. CONTE. I have seen recent newspaper and magazine reports about genital herpes, a sexually transmitted viral disease. How much is known about this disease?

Dr. SENCER. Not much is known. We do know that it is a recurring viral disease, that it causes acutely painful genital lesions, that it is spread sexually, and that no really effective treatment is available. It kills or mentally retards more than one-half of the newborns who are thought to be infected at birth, and is increasingly believed to be a major cause of cervical carcinoma.

Mr. CONTE. Is there a need for more research into its manifestations and transmission?

Dr. SENCER. Research should continue into the complications, diagnosis, treatment, the modes of transmission during the inactive stage, and the development of a vaccine.

Mr. CONTE. What are you doing to take these other sexually transmitted diseases into account in your federally funded venereal disease clinics?

Dr. SENCER. We are encouraging venereal disease clinics, which are all funded by State and local governments, to diagnose and treat other sexually transmitted diseases as an adjunct to controlling syphilis and gonorrhea, and as a service to the general population. Additionally, we have established surveillance systems in two cities to determine the prevalence of most significant of these diseases, and the feasibility of developing control strategies.

LEAD-BASED PAINT POISONING PREVENTION

Mr. CONTE. Your budget for lead-based paint screening reflects your desire to see increased State and local contributions as well as

reimbursement for Federal training. Have you any hard evidence to support a proposition that State and local governments have additional resources to devote to such screening?

Dr. SENCER. Funds appropriated for childhood lead poisoning prevention programs have been used to stimulate State and local resources for this program. In fiscal year 1974, 10 percent matching funds were required, however, it was reported by the grantees that 33.5 percent of the funds available for program activities were local funds. This trend is expected to continue as programs develop greater local support and as alternative funding sources are explored. Third-party payments, including the early periodic screening, diagnosis and treatment programs, title V (SSA), and HUD community block grants, are funding sources which are, and can be, utilized for continuing support for these programs. Some States, such as New York and Massachusetts, do not have a Federal grant but are presently supporting screening programs. With the establishment of State laboratory lead analysis capability during fiscal year 1975, it is expected that other States will follow suit. It is our opinion that if authority were extended to permit us to make grants to States, additional local resources could be generated.

In 1976 there is a further extension of the fee-for-service policy with respect to the training of State and local health workers. For the past 2 years CDC would waive the fee for service when the training was judged to be in the public interest. CDC will continue to offer training courses, but only to the extent that State, local, and other health organizations are willing to reimburse the Center for the costs of such training.

Mr. CONTE. How many children in this country would you estimate are at risk and need to be screened?

Dr. SENCER. The vast majority of lead poisoning occurs in children under 6 years of age, generally residing in urban areas in deteriorating housing containing lead paint. There are approximately 2½ million children in this age group. This group is in a continuing state of change due to births, maturation, and movement in and out of housing with conditions conducive to lead poisoning. These children should all be tested at least once a year.

Mr. CONTE. How many of these have been screened so far?

Dr. SENCER. Since the initiation of the grant program, federally assisted projects have screened approximately 866,000 children.

Mr. CONTE. How many do you think will be screened under your proposed budget this year?

Dr. SENCER. We are currently projecting that 211,000 additional children will be screened for the first time with the funds requested in the fiscal year 1976 budget.

Mr. CONTE. At this rate, when will all at-risk children have been screened?

Dr. SENCER. These project grants are designed to assist cities in developing programs, and will never succeed in screening all children at risk.

Mr. CONTE. You said that since 1972 about 70,000 children had been found with elevated blood lead levels, but that hazard reduction had been accomplished in only 24,000 dwelling units. Allowing for the fact that many children with elevated lead levels may have come from

the same dwelling, how many of these children were simply sent back into their high-risk-of-exposure environment?

Dr. SENCER. Screening programs are urged not to return children with undue lead absorption to a high-risk home environment. However, of those homes inspected, only 60 percent are determined to contain significant lead-paint levels.

Mr. CONTE. It seems that with local resources and minimal Federal support, the progress on reduced hazards has been much too slow. Would you care to comment on that?

Dr. SENCER. One problem is technical; existing portable lead analyzers do not have adequate sensitivity. They often miss significant lead levels. We expect to have more sensitive instruments in the very near future. Moreover, the child is often exposed to lead at a site other than in his home. Thorough epidemiological investigations are needed. There are some administrative breakdowns as well. The agency screening the child often must refer the environmental investigation to another agency. This, as you can imagine, can result in communications problems. However, we are emphasizing good case management practices with grantees and are seeing real progress. Let me make another point. Ongoing medical followup of the child and educating the parents on simple housekeeping practices are often enough to prevent repeating incidents of paint ingestion.

Mr. CONTE. What is the current status of the development of State laboratory capacity to perform blood lead level analysis?

Dr. SENCER. During fiscal year 1974, 28 State laboratories were funded to develop blood lead analysis capability. Those that are operational are presently being monitored by the CDC proficiency monitoring program for blood lead analysis. The remainder should be functioning within the next few months. In addition, five other States, the District of Columbia, and Puerto Rico are participating in the CDC proficiency monitoring program, as are 65 local and private laboratories.

Mr. CONTE. How many laboratories are currently able to perform such analysis?

Dr. SENCER. Our records show that over 80 percent of all reporting laboratories were able to obtain satisfactory results.

Mr. CONTE. Where are they located?

Dr. SENCER. Federally assisted State laboratories include, or will soon include those in: Alabama, Arkansas, California, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Virginia, Wisconsin, and Wyoming.

Mr. CONTE. Does every State have at least one?

Dr. SENCER. State laboratories which do not have a Federal grant but who are participating in the proficiency testing program include Delaware, South Carolina, Puerto Rico, District of Columbia, Louisiana, Kansas, and Texas. Not all States are represented in the monitoring program nor are blood lead analysis facilities available in every State.

Mr. CONTE. I wonder if you could just elaborate, and justify in detail sufficient to explain to my colleagues on the floor of the House, exactly how we can reduce Federal project grant funding for blood-lead level

testing when the problem does not seem to be adequately dealt with even at present budget levels?

Dr. SENCER. There are a number of other funding resources which are available to State and local communities to carry out screening programs directed at children at risk for undue lead absorption. Most prominent among these is the early periodic screening, diagnosis and treatment program which recommends a blood analysis for undue lead absorption as a part of its screening package. Forty-nine of the 50 States now accept lead screening as a reimbursable expense. In addition, maternal and child health programs (title V, Social Security Administration), Head Start, neighborhood health centers, and children and youth projects all should screen children for lead poisoning detection. Additionally persons hired under the emergency employment provisions of the Department of Labor's CETA can appropriately be used to carry out various activities associated with screening programs. The use of HUD community development funds in alleviating lead paint hazards is also appropriate. In fact, if community screening programs would utilize all resources available to them, activities could be significantly increased.

RAT CONTROL

Mr. CONTE. You are requesting a $7.7 million decrease in project grants for rat control. Why? What progress has been made in rat control? How much more could you do with this additional $7.7 million?

Dr. SENCER. Urban rat control grants were intended to serve as seed money. They are intended to stimulate ever-increasing local support of program activities. As the severity of the problem is reduced, total withdrawal of Federal support can occur. In addition, other resources have become available. These include the use of persons employed through the Department of Labor's CETA program and HUD Community Development Act funds. It is expected that Federal support of most grants can thereby be reduced in fiscal year 1976, thus permitting the budget reduction. An indication of significant progress occurs when a rat control program has attained a goal where 80 percent or more of its target area blocks have achieved a maintenance level. The seven community programs that have already achieved this level of success are Buffalo, N.Y., Syracuse, N.Y., District of Columbia (war on rats program), York, Pa., Flint, Mich., New Orleans, La., and Seattle, Wash.

An additional 18 projects have 50 percent or more of their target area blocks at the maintenance level. While the percentage of blocks in maintenance in some target areas may be low, some programs have markedly reduced rat infestations in their community. It is estimated that there are an additional 250 cities which still have severe domestic rat infestations. Any increase in grant funds could be utilized to support programs in these communities.

LABORATORY IMPROVEMENT

Mr. CONTE. You have cited progress in laboratory improvements. How do you measure such progress, and using your criteria, how much of this progress was made in the past year? What are your long-term goals for laboratory improvement, and to what extent will the budget

which you are requesting move toward those goals? How much of this improvement do you attribute to Federal support, and how much to other sources?

Dr. SENCER. Progress is measured against standards established for personnel, quality control, and proficiency testing. Conformance to the personnel standards is complete and thus, we feel our objectives are achieved on a continuing basis. In the area of quality control, we measure progress in terms of the declining number of deficiencies found in successive on-site examinations. By the third examination most laboratories are complying with literally hundreds of quality control requirements which we feel are requisite for adequate clinical laboratory practice.

In the area of proficiency testing, we measure progress in several ways. Two of the ways which can be described verbally include looking at a subset of laboratories who have been in the program for approximately the same length of time. For these laboratories we can establish, by proficiency testing component, their average grade and we can establish, for the subset, the range of their grades. That is, the difference between the highest grade and the lowest grade of the group. Over time, for practically all proficiency testing components, we find a relatively constant upward trend in the performance of laboratories. That is, the average grade of the subset steadily improves and the range between the highest and lowest grades steadily decreases.

In dealing with trend data, it is difficult to quantify accomplishment within a given year. Qualitatively, we feel that major accomplishments during the past year, over and above improvement trends, has consisted in progress toward the development of uniform standards in quality control, proficiency testing and personnel and the development of procedures and mechanisms to assure that the uniform standards can be uniformly applied.

Progress in laboratory improvement is also measured by the development of the technological tools such as methods, materials, and quality control systems, for good laboratory work, and the transfer of the technology to the health laboratories. While it is true that such measures are indirect, they must serve as appropriate indicators of the early stages, just as proficiency testing serves as the indicator of the later stages of laboratory improvement.

I would estimate that in the last 10 years, about one-half of the visible progress has occurred during the last 2 years. It should be recognized that recent progress is being built on the basis of national consensus acceptance developed during the past 10–15 years largely by CDC.

Our long term goals for laboratory improvement include completion of the previously mentioned standard setting process and finalization of mechanisms for uniform applications so that States and public and private associations can assist, in a consistent, objective, effective and efficient way, in insuring the public that the services provided by some 15,000 clinical laboratories meet or exceed the minimal standards established. The budget we have requested should allow us to maintain a rate of progress toward established objectives which is commensurate with our technical resources and the ability of the scientific community to constructively assimilate the proposed changes. As to the improvement in laboratories, overtime, which is attributable to Federal support, we would note first the highly commendable efforts of States and

professional associations within the context of their own program objectives. The extent to which Federal support is ultimately effective can best be measured prospectively when a uniform system for standard setting and application of standards is in place. We can say with certainty that such a system cannot be established in the absence of Federal support.

Training of Medicare Surveyors

Mr. Conte. You say that you are developing a training program for medicare laboratory inspectors. How much money do you intend to use for this? Why do you consider this important, but you are seeking State and local reimbursements for training blood-lead level technicians?

Dr. Sencer. With regard to existing quality control regulations, we have recently put on training sessions in Chicago, Atlanta, and San Diego so that all, or practically all, medicare surveyors could attend and so that we can begin to work toward uniformity of application of standards. Revised quality control regulations are currently in draft form and upon their publications we will again establish a series of training sessions for medicare surveyors. We have developed checklists keyed to the regulations and we are developing an examiner's handbook which is keyed to both the regulations and the checklists. Pending training sessions will focus on the regulations, the checklists and the handbook concurrently with the objective of achieving uniformity in standards application. Further training needs will be identified through our ongoing monitoring and validation efforts with State surveyors in their application of standards. We consider this a matter of greatest importance and expect that objectives can be accomplished within the budget requested.

Costs to provide this training are minimal involving travel and per diem for trainees and will be borne by the Social Security Administration under an interagency agreement. Thus, our training of medicare surveyors is not inconsistent with our current training reimbursement policies or with those policy changes which take effect in 1976. With elimination of the waiver clause State and local health departments and other recipients of CDC training will have to reimburse the center for the cost of the training, just as the Social Security Administration is doing. This change is a further extension of the fee-for-service policy of the administration.

Diagnostic Reagents

Mr. Conte. What is the nature of your cooperation with the Food and Drug Administration in the development of diagnostic reagents? How many of these have you developed? How many more do you think we need?

Dr. Sencer. The CDC and FDA have developed a draft interagency agreement outlining the responsibilities of each agency in the area of in vitro diagnostic products regulation. The most important part of the FDA program is the development of product class standards for individual products or groups of related products. CDC will advise FDA on the practicality of particular product class standards, and help to identify those characteristics which should be addressed. While FDA

51-805 O - 75 -- 25

has the responsibility for coordination, development, promulgation, and enforcement of product class standards the FDA will offer CDC the first opportunity to develop what is called the scientific basis of a product class standard. Once CDC has utilized its technical competence to develop the scientific basis for a product class standard and has submitted the information to the FDA it will be bound by the regular FDA policies and guidelines until publication in the Federal Register.

The CDC will also have other functions in the FDA in vitro diagnostic products program. As far as compliance is concerned, that responsibility rests with the FDA and any inquiry will be referred there. However, CDC will provide opinions to manufacturers and consumers on the absence of information clearly required by law or regulations, or opinions on the accuracy of labeling statements based on product development or evaluation work done at the CDC. In addition, the FDA will forward to CDC reports received through the product problem reporting system, and reports of all regulatory actions taken and significant voluntary industry corrections. The CDC will review and evaluate these reports and furnish the FDA with any available information on individual products or batches, or any information based on general experience with the product or its related methodology.

Finally, on request from the FDA, the CDC will perform product evaluations in areas where it has scientific capability in order to support FDA regulatory responsibilities. This will include the selection and development of appropriate testing protocols, the acquisition of appropriate specimens, the testing of products, and the preparation of reports for FDA's use in a regulatory action.

In summary, the CDC will serve as the primary source of technical capability for the FDA in the development of its regulatory program, will serve as an interface with the scientific community, and will conduct technical studies related to product performance.

Thus far, product class standards have been developed for six product areas: glucose, calibrators in clinical chemistry, hemoglobin, rabies, rubella, and nontreponemal tests for syphilis. In addition, CDC has performance specifications for approximately 2,000 in vitro diagnostic products which will serve as the scientific basis for development of product class standards. The need for standards increases proportionally with the number of new diagnostic products reaching the commercial market.

Laboratory Diagnosis

Mr. Conte. You mentioned the development of better methods of laboratory diagnosis. Would you give some examples of areas in which you are currently doing work, and some areas in which you feel you have made significant advances?

Dr. Sencer. We are currently conducting research on tests used for the detection, prior to birth, of defects such as mongolism which are associated with chromosomal abnormalities, tests for the identification of immunodeficiencies, and rapid serologic tests for the diagnosis of mycotic diseases which have assumed a position of increased significance in patients with chronic diseases or who are undergoing therapy with immunosuppressive drugs. We have developed standard proce-

dures for the diagnosis of rubella, toxoplasmosis, herpesvirus, and cytomegalovirus infections which are associated with a variety of birth defects or mental retardation, and for the measurement of certain amino acids associated with inborn errors of metabolism in the newborn and which can be controlled through diet.

The Center has also developed an intensive surveillance program in the nationwide gonorrhea therapy monitoring program using laboratory procedures for the identification of the gonococcus, and has contributed to the effectiveness of the National Heart and Lung Institute (NHLI) clinical trials by assuring high quality laboratory services. In addition, we have published the "Guidelines for Phenotype Analysis of Lypoprotein Patterns in the Clinical Laboratory," conducted an international prothrombin time trial, cooperated with the State Department in the establishment of two lipid laboratories in Russia, and cosponsored with the World Health Organization an International Conference on Standardization of Diagnostic Materials and Methods, which led to the adoption by WHO of a diagnostic products program.

Significant advances were made in the development of national reference methods and materials for glucose, uric acid, electrolytes, calcium, immunoglobulins, hemoglobinopathies, and coagulation tests, as well as techniques for the growth and transport of gonococci, performance of radioimmunoassays, preparation of FDA fluorescent antibody conjugates for dental caries screening, and differentiating viruses in the Bunyaviruses group (150), several of which are pathogenic to man.

Laboratory Improvement

Mr. Conte. You said that you are continuing efforts in laboratory improvement, and yet you are requesting a decrease of 40 positions in this category. Why?

Dr. Sencer. Our efforts to improve laboratory performance will continue at the level originally proposed in the 1975 budget. The decrease of 40 positions relates to the expanded activities involved in the $700,000 added to the 1975 appropriation by Congress. The Department has requested that $530,000 of that amount be reprogramed to cover increased pay costs this year. Thus, the proposed reduction would bring the 1976 budget in line with the President's request for 1975.

Lead-Based Paint Poisoning

Mr. Conte. Many authorizations for project grant programs—sections 317(d)(2) and 318(d)(2) of the PHS Act and the Lead-Based Paint Poisoning Prevention Act of 1973—expire on June 30. Are you requesting extensions of these authorizations?

Dr. Sencer. The administration will soon be submitting a legislative proposal to deal with these expiring authorizations. In general, we believe that they should be extended, but not as separate forms of grant assistance. Some consolidation is needed.

Venereal Disease

Mr. Conte. In your justification it said that educational programs "will be directed toward providing information about the venereal

diseases to persons at high risk of acquiring infection." By what criteria do you consider people to be of "high risk"?

Dr. SENCER. The people at high risk for venereal disease are single and are between the ages of 15 and 34. The highest risk group includes this same category of people who have been exposed to or have been previously infected with a venereal disease or who reside in census tracts where the rates of disease are very high.

TUBERCULOSIS

Mr. CONTE. How much do you intend to spend on tuberculosis programs this year compared to last year?

Dr. SENCER. Our in-house programs for tuberculosis control, including clinical research and technical assistance will continue at 1975 funding levels. Most States have used some of their 314(d) formula grant funds to support tuberculosis control activities in 1975, and these funds will be eliminated in 1976. We estimate that $12 million or $13 million in 314(d) funds are being used in fiscal year 1975 to support tuberculosis in control activities.

COMPREHENSIVE HEALTH FORMULA GRANTS

Mr. CONTE. I have received many letters from Massachusetts concerning the termination of comprehensive health formula grants, and the disastrous effect this would have on TB control, which is a great problem in Massachusetts. Do you still intend to terminate comprehensive health formula grants, and you can give me a good justification for such action?

Dr. SENCER. While this program is not a part of the preventive health services appropriation, I can make a general comment. A major reason for terminating this program is that these funds are used primarily to support activities which are clearly State and local responsibilities, or which are already being assisted with other Federal funds. In general, it is felt that States are in a relatively better position to step up their funding of public health programs than is the Federal Government.

BIRTH DEFECTS

Mr. CONTE. Would you elaborate on the work of your birth defect monitoring program?

Dr. SENCER. Th birth defects monitoring program was established in an effort to provide such an early warning system for this country.

The program, under development since 1970, has come about with the joint efforts of the Center for Disease Control, the National Institute of Child Health and Human Development, the National-March of Dimes, and the Commission on Professional and Hospital Activities. Beginning in December 1974, the program began regular systematic analysis of hospital discharge summaries on over 1 million U.S. infants born in some 1,500 hospitals. These data are being monitored for trends and unusual patterns suggestive of environmental etiology. Where the incidence patterns are suspect, other analysis, including field investigations, are conducted to look for environmental causative agents.

As you know, the drug thalidomide caused an epidemic of birth defects in countries where the drug was used. There is a real possibility that a drug or other environmental agent might cause another epidemic of birth defects. Should such an epidemic occur, we would want to end it as soon as possible. Before work could be undertaken to find the cause of the epidemic, we must be aware that the incidence of birth defects is increasing. One way to learn early of an increasing incidence of a birth defect is to systematically and regularly monitor the incidence of birth defects.

HEALTH EDUCATION

Mr. CONTE. Would you describe some of your major health education projects?

Dr. SENCER. The principal role of the Center for Disease Control as a Federal focal point is to encourage, support, and assist other agencies in carrying out their appropriate health education functions and to supplement and strengthen the programs of other agencies. This types of focal point was consciously and deliberately selected in the development of the DHEW response to the President's Committee report. It is based up on the principle that each PHS agency and program retains ultimate responsibility for the health education activities essential to the fulfillment of its mission.

A survey of program activities is now being conducted by the Center to identify and enumerate projects with health education content. The survey will provide information concerning whether or not departmental agencies are meeting legislative mandates under which they they perform health education activities; what approaches are being used and what the actual accomplishments are; and what population groups are being reached. The survey will produce a data base which will be made available to other agencies within the Department and to nongovernmental interests which ask for our help.

The Center has also developed health education curriculums for grades 4, 5, 6, and 7, which provides the children in these grades with an exciting learning experience in understanding and dealing with health problems. The success of this project is directly related to the training of teacher-administrator teams and the involvement of parents and community health resources.

In May 1974, a contract was let with the National Health Council to explore the feasibility and recommend the functions, structure, and organizational nature of a private-sector based National Center for Health Education as proposed by the President's Committee on Health Education.

A new adult prevalence survey, a continuation of baseline data on adult attitudes and behavior about cigarette smoking that was begun in 1964, is currently underway. These data provide a solid basis for comparisons in the changing nature of the cigarette smoking problem, for example, the decrease in percentage of male smokers as compared with the sharp increase in female smokers; increased use of filter tip cigarettes; and most important, corresponding changes in attitude toward smoking. The current adult prevalence survey also includes an evaluation of Tel-Med, the medical tape library functioning in 35 U.S. cities.

School health curriculum projects now include the fourth grade and are in place in 125 school districts across the country. New health

education demonstration contracts directed toward special target groups such as Mexican Americans, the handicapped, and poor in Texas; Indian and rural populations in New Mexico; rural and agricultural populations in Arkansas; and patients and consumers in Tuskegee, Ala., are being implemented for replication or adaptation in other communities. Other new endeavors include the promotion of comprehensive school and community health education through the PTA in cooperation with the Office of Education.

In practice, a majority of the Center's direct service category health education programs are a joint endeavor under a reimbursable agreement with the National Cancer Institute, National Institutes of Health. Also, under consideration is a reimbursable agreement with the National Heart and Lung Institute to carry out other health education programs of mutual benefit.

Mr. CONTE. Is there any overlap or duplication?

Dr. SENCER. A primary function of the Center is to develop and recommend to the Department guidelines and standards for health education programs. Results of the survey of Department program health education activities now underway will be reported back to the agency heads for the purpose of assisting them in solving program problems, including problems of overlap and duplication of effort.

Mr. CONTE. Would it be better to put all health education programs under the Center for Disease Control?

Dr. SENCER. No; the creation of a Federal focal point for health education within one of the Department's agencies does not absolve the other agencies of their program responsibilities in the area of health education.

The alternative of separating the educational components of all health programs and integrating them into a massive new health education agency was deemed unacceptable on both philosophical and highly practical grounds.

Mr. CONTE. How much of this is for smoking education?

Dr. SENCER. Antismoking accounts for at least a portion of all health education projects currently in effect. The Center is expanding contract and project activities previously limited to smoking and health to include a wider range of health education concerns, but smoking related program activities continue to underly virtually all newly initiated projects. For example, we have projects to develop educational materials and approaches to stimulate smoking and health education by health professionals working in minority communities; to develop and integrate smoking and health education services into a model family planning clinic; to develop and test prototype curriculum units for upper junior high school youth; to broaden to other grades our smoking and health curricula used in the fourth through seventh grades of 1 to 125 school districts across the country; to develop smoking cessation measures for junior and high school age youth; and to launch model smoking and health projects to serve rural low income migrant workers and minorities. These are just a few of our projects which include smoking education.

Mr. CONTE. How much for drug and alcohol education?

Dr. SENCER. Although the Bureau of Health Education works directly with the National Institute on Alcoholic Abuse and the National Institute on Drug Abuse in cooperative projects, the elementary educa-

tion health curriculum project is the only study currently directed toward alcohol and drug abuse.

Mr. CONTE. How do you coordinate with the various Institutes of Health and their education programs?

Dr. SENCER. Since health education activities are carried out in most of the agencies of the Department, an intradepartmental panel for health education of the public has been established to serve as a central focus for the development and promulgation of Department-wide health education policies, and to encourage multiagency health education activities. The panel is chaired by the Assistant Secretary for Health and comprises the six PHS agency heads, a regional health administrator, Assistant Secretary for Education, heads of medicare and medicaid programs and several staff offices from the Office of the Secretary.

Mr. CONTE. When we are spending a great deal of money on cancer research and health education programs on the dangers of smoking, do you think it is appropriate to continue to support tobacco production through various agricultural assistance and export programs?

Dr. SENCER. From a health standpoint, no.

OCCUPATIONAL INSULT EXPOSURE

Mr. CONTE. You said that an estimated more than 100,000 premature deaths occur annually due to occupational insult exposures. While I can appreciate your desire to substantiate this figure, I am more interested in what you are going to do about it. You mentioned such disease-inducing agents as vinyl chloride, arsenic, asbestos, chloroprene, and others. Is it possible to absolutely isolate workers from exposure to these substances? How can this be done—give a couple of examples, if you will? Is it necessary to isolate workers from the substances, or is it possible to merely reduce exposure levels and achieve the desired results?

Dr. SENCER. In most existing plants it is not possible, except in rare and unusual circumstances, to absolutely isolate workers from the substances with which they work, because, for example, while production workers may be protected by isolation techniques, the maintenance personnel must enter the isolated area to repair, clean, or manipulate the machinery. An example of complete isolation that has been successfully executed is the handling of radioisotopes initiated since the development of atomic weapons. Isolation of workers from the production process is not always necessary. Except for the chemical carcinogens for which no safe concentration is known, safe exposure concentrations for a great majority of chemicals which comprise the major chemical output of industry are known or can be determined. Establishing these safe concentrations based on occupational health studies and research is the purpose of the criteria documents prepared by NIOSH. Establishing these safe levels is essential to the economic development of the country, in order that undue displacement of capital or labor will not be advocated without valid evidence that the substance would be injurious to health.

OCCUPATIONAL SAFETY

Mr. CONTE. I think that most of us are generally familiar with the techniques and procedures of biomedical research. You mentioned in-

creased attention to occupational injuries by NIOSH. Could you describe some of the approaches and methods used in research on occupational injuries?

Dr. SENCER. The development of an occupational injury research program involves at least four major steps.

The first of these is to identify those agents such as machines, tools, equipment, or activities which are involved or associated with the greatest number of deaths and injuries both serious and nonserious.

Second, develop a priority formula that would enable these agents or activities to be arranged in an order of priority based upon both the population at risk and the probability of successful results.

Third, develop data on the cause and effect relationships of these agents or activities as they relate to the occurrences through analysis of past experience and/or an indepth investigation of occurrences and then develop a system of collecting current and future information that will identify those agents and/or activities for which a cause and effect relationship has been established.

The fourth step is to isolate those factors that are involved in this cause and effect relationship, to determine those factors which lend themselves to correction or modification, and to develop criteria, including good work practices, for promulgation of standards having a measurable effect upon the results.

Mr. CONTE. To what extent does your jurisdiction in something like occupational safety and injuries, as opposed to environmental disease, overlap with OSHA? Is there some duplication of effort there?

Dr. SENCER. NIOSH's principal role is research to develop scientific criteria upon which new or improved safety standards can be developed. Such recommended standards, would be officially transmitted to the Occupational Safety and Health Administration in the same manner as would a standard dealing with an occupational disease hazard.

One provision of section 2 of the Occupational Safety and Health Act, paragraph b(5) specifically provides for research in the field of occupational safety and health including the psychological factors involved. NIOSH, therefore, is performing research designed to identify both psychological, human, and engineering factors that are involved in occurrence of occupational injuries.

Most of the current safety standards were derived from voluntary concensus standards which were developed by interested parties on the basis of their best judgments, rather than scientifically developed criteria.

The Occupational Safety and Health Administration has as its primary responsibility the promulgation of standards based upon the best information available to them. After the standards have been promulgated in final form, OSHA is responsible for their enforcement either through their own staff or by agreement with States.

Thus, there is no duplication in effort between NIOSH and OSHA since NIOSH's role is to perform the research necessary for OSHA to promulgate new and improved standards in the safety area as well as the health area. In many industries and occupations the worker is exposed to many hazards concurrently. For example, the worker in a

machine shop is exposed to noise, inhalation of oil mists, and machine hazards all at the same time. Excessive noise levels could contribute to the accident on the machine that results in a tramatic injury.

Occupational Carcinogens

Mr. Conte. You mention your expanded program in research on occupational carcinogenesis. I think this is an area which needs greater attention, but I wonder how much of this work is being done at the Cancer Institute, and how much you may be overlapping with some of their work?

Dr. Sencer. There is no overlap of the NIOSH carcinogenesis program with the programs of the National Cancer Institute (NCI). NIOSH's program includes epidemiologic and occupational health surveys of the workers handling carcinogens or substances suspected of having carcinogenic activity and studies of the concentrations found in the occupational environment. The major responsibility of the NCI is in the area of experimental carcinogenesis research on laboratory animals. A NIOSH proposed study on the effects of rats exposed to vinyl chloride has been coordinated very closely with researchers at NCI.

Assistance for Disaster-Related Health Problems

Mr. Conte. I understand that your study on assessing the need for technical assistance to States and localities for management of disaster-related health problems was completed in February. Could you tell us the major conclusions of that study?

Dr. Sencer. The study was to determine the feasibility of assessing the need for technical assistance to State and local jurisdictions for the appropriate management of community health problems associated with natural and man-made disasters.

The study recommends that resources be made available for an indepth assessment of the need for Federal technical assistance. The plan for performing such an assessment would include gathering and analyzing data on current disaster response capabilities, identifying and evaluating existing emergency relief plans and procedures, and determining the need for the most effective means of Federal technical assistance.

Such an assessment would take 9 months from date of implementation to completion and would require $157,000 and 5.25 man years or 7 persons for 9 months.

The Center, with its professional and technical expertise and operational capability in providing epidemic assistance, is in an excellent position to conduct this type of assessment.

Common Communicable Diseases

Mr. Conte. Would you provide us with a list of 8 or 10 most common communicable diseases with the number of cases reported over the past 3 years or so?

Dr. Sencer. The following table provides the information requested.

8 MOST COMMONLY REPORTED NATIONALLY NOTIFIABLE COMMUNICABLE DISEASES

	1974	1973	1972	1971
Gonorrhea	898, 943	842, 621	767, 215	670, 268
Chickenpox	122, 087	182, 927	164, 114	
Syphilis	83, 771	87, 469	91, 149	95, 997
Viral Hepatitis	59, 831	59, 200	63, 476	69, 162
Mumps	57, 429	69, 612	74, 215	124, 939
Tuberculosis	30, 333	30, 998	32, 275	35, 217
Measles	22, 119	26, 690	32, 275	75, 290
Rubella	11, 845	27, 804	25, 507	45, 086

Mr. CONTE. That is all Mr. Chairman.
Mr. FLOOD. Thank you, Dr. Sencer.
Dr. SENCER. Thank you, Mr. Chairman.

Justification of the Budget Estimates

Appropriation Estimate

PREVENTIVE HEALTH SERVICES

To carry out, to the extent not otherwise provided, Title III of the Public Health Service Act, the Lead-Based Paint Poisoning Prevention Act, the Federal Coal Mine Health and Safety Act of 1969, and the Occupational Safety and Health Act of 1970; including insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft; [$136,443,000] *$133,311,000: Provided,* That training of employees of Federal, State, and local governments and of private agencies, shall be made subject to reimbursement or advances to this appropriation for the full costs of such training.

For "Preventive Health Services", for the period July 1, 1976, through September 30, 1976, including insurance of official motor vehicles in foreign countries, and purchase, hire, maintenance, and operation of aircraft; $33,328,000: Provided, That training of employees of Federal, State, and local governments and of private agencies shall be made subject to reimbursement or advances to this appropriation for the full costs of such training. (Department of Health, Education, and Welfare Appropriation Act, 1975; additional authorizing legislation to be proposed for $33,710,000 for fiscal year 1976 and $6,500,000 for the period July 1, 1976, through September 30, 1976.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CENTER FOR DISEASE CONTROL

Preventive Health Services

Amounts Available for Obligation 1/

	1975 Estimate	1976
Appropriation	$136,443,000	$133,311,000
Pending request Rat control project grants authorized under the Continuing Resolution	+13,100,000	---
Subtotal, adjusted appropriation	149,543,000	133,311,000
Comparative transfers to:		
"Departmental management" Establishment of Office of Assistant Regional Director for Public Affairs in each region.	-27,000	---
"Assistant Secretary for Health" Automated terminal system.	-3,000	---
"Health resources" Transfer of production of Health Service Reports.	-17,000	---
Subtotal, budget authority	149,496,000	133,311,000
Unobligated balance, transferred from other accounts	+3,288,000	---
Total, obligations	152,784,000 2/	133,311,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1975 - $10,000,000; 1976 - $10,000,000.

2/ Excludes $440,000 of obligations from the 1973 released funds.

Summary of Changes

1975 estimated obligations	$152,784,000
1976 estimated obligations	-133,311,000
Net change	-19,473,000

	1975 Base Pos.	1975 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Annualization of positions new in 1975	---	---	---	+$811,000
2. Annualization of pay raises	---	---	---	+1,220,000
3. Within-grade pay increases	---	---	---	+1,085,000
4. One extra day of pay	---	---	---	+362,000
5. GSA rent increase	---	---	---	+1,600,000
6. Annualization of Federal Employees Health Benefits increase	---	---	---	+4,000
7. Office of Federal Employees Compensation increase	---	---	---	+54,000
8. FTS, postage and utility increases	---	---	---	+324,000
9. Increased Department Working Capital Fund	---	---	---	+110,000
10. Increased PHS Service and Supply Fund	---	---	---	+15,000
11. In-service training required by OMB Cir. A-48	---	---	---	+95,000
12. Safety requirements of PL 91-596.	---	---	---	+83,000
13. Increased maintenance cost of Clifton Road building complex	---	---	---	+98,000
Subtotal			---	+5,861,000
B. Program:				
1. Occupational health - Direct operations	660	$27,734,000	+13	+1,272,000
Subtotal			+13	+1,272,000
Total, increases			+13	+7,133,000
Decreases:				
A. Built-in:				
1. Health education	---	---	---	-21,000
2. Occupational health - Grants	---	---	---	-352,000
Subtotal			---	-373,000

	1975 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
B. Program:				
1. Disease control - Project grants	597	53,498,000	-34	-19,788,000
2. Disease control - Disease investigations, surveillance, and control	1,503	42,251,000	---	-916,000
3. Laboratory improvement	509	9,573,000	-40	-241,000
4. Occupational health - grants	---	4,252,000	---	-2,000,000
5. Buildings and facilities	---	3,288,000	---	-3,288,000
6. Program management	264	9,161,000	---	---
Subtotal			-74	-26,233,000
Total, decreases			-74	-26,606,000
Total, net change			-61	-19,473,000

Explanation of Changes

Increases:

A. Built-in:

An increase of $5,861,000 includes $811,000 for annualization of positions new in 1975; $1,220,000 for annualization of pay raises in 1975; $1,085,000 for within grade increases; $362,000 for one extra day of pay; $1,600,000 for increased GSA building space rent; $4,000 for annualization of Federal Employees Health Benefits increase; $54,000 for Office of Federal Employees Compensation increase; $324,000 for FTS, postage, and utilities increase; $110,000 for increased Department Working Capital Fund; $15,000 for increase of PHS Service and Supply Fund; $95,000 for in-service training required by OMB Circular A-48; $83,000 for cost of safety requirements of PL 91-596; and $98,000 for increased maintenance cost of Clifton Road building complex.

The increase of $5,861,000 includes $2,094,000 for Disease control - Disease investigations, surveillance, and control; $657,000 for Disease control - Laboratory improvement; $7,000 for Disease control - Health education; $1,275,000 for Occupational health - Direct operations; and $1,828,000 for Program management, including $1,600,000 for GSA rent.

B. Program:

1. Occupational health - Direct operations

An increase of $1,272,000 and 13 positions will support an expanded comprehensive program in occupational carcinogenesis. Surveillance efforts will be initiated, including the acquisition and analysis of occupational data; support will be provided for four industry-wide epidemiological studies; and laboratory research will be carried out to provide the necessary engineering control, design technology, and development of necessary criteria for work practice controls to insure safe and healthful working environment.

Explanation of Changes (Continued)

Decreases:

A. Built-in:

A decrease of $373,000 includes $352,000 from Occupational health non-competing research grants terminating in 1975, and $21,000 non-recurring equipment purchases in Health education.

B. Program:

1. Disease control - Project grants

The decrease of $19,788,000 and 34 positions in project grants includes $5,358,000 and 32 positions for venereal disease; $1,240,000 and 2 positions for immunization; $7,690,000 for rat control; and $5,500,000 for lead-based paint poisoning prevention. The reductions in venereal disease and immunization project grants results from expectation that State and local funding will be increased. The rat control project grant reduction will be accomplished by terminating grant assistance to communities after the sixth year. The reduction in lead-based paint poisoning prevention will be accomplished by terminating low yield projects and by (a) encouraging early diagnosis and treatment under medicaid and other health service delivery programs, and (b) utilizing the strengthened capability of State health laboratories to perform blood-lead analysis.

2. Disease control - Investigations, surveillance, and control

The decrease of $916,000 results from the change in reimbursement policy which requires State, local, and other organizations to pay for short-term health training provided by the Center for Disease Control.

3. Disease control - Laboratory improvement

The decrease of $241,000 and 40 positions results from the one-year funding in 1975 of efforts to expand the development of product class standards in cooperation with the Food and Drug Administration.

4. Occupational health - Grants

The decrease of $2,000,000 results from the one-time funding in 1975 of the training grant program.

5. Buildings and facilities

The decrease of $3,288,000 results from the planned obligation in 1975 of all funds appropriated but not obligated in prior years with no new obligational authority being requested in 1976.

Obligations by Activity

Page Ref.		1975 Estimate Pos.	1975 Estimate Amount	1976 Estimate Pos.	1976 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
	Disease control:						
133	(a) Project grants .	597	$53,498,000	1/ 563	$33,710,000	-34	-$19,788,000
137	(b) Disease investigations surveillance and control	1,503	42,251,000	1,503	43,429,000	---	+1,178,000
148	(c) Laboratory improvement ...	509	9,573,000	469	9,989,000	-40	+416,000
153	(d) Health education	36	3,027,000	36	3,013,000	---	-14,000
156	Occupational health:						
	(a) Grants	---	4,252,000	---	1,900,000	---	-2,352,000
157	(b) Direct operations	660	27,734,000	673	30,281,000	+13	+2,547,000
160	Buildings and facilities	---	3,288,000	---	---	---	-3,288,000
161	Program management .	264	9,161,000	264	10,989,000	---	+1,828,000
	Total obligations.	3,569	152,784,000	2/ 3,508	133,311,000	-61	-19,473,000

1/ Includes $13,100,000 for Rat Control grants not authorized but requested in 1975 President's Budget.
2/ Excludes $440,000 of obligations from the 1973 released funds.

Obligations by Object

	1975 Estimate	1976 Estimate	Increase or Decrease
Total number of permanent positions	3,569	3,508	-61
Full-time equivalent of all other positions	200	200	---
Average number of all employees	3,402	3,427	+25
Personnel compensation:			
Permanent positions	$52,721,000	$55,546,000	+$2,825,000
Positions other than permanent	1,778,000	1,803,000	+25,000
Other personnel compensation	1,250,000	1,272,000	+22,000
Subtotal, personnel compensation..	55,749,000	58,621,000	+2,872,000
Personnel benefits	7,691,000	8,019,000	+328,000
Travel and transportation of persons ...	3,097,000	3,097,000	---
Transportation of things	738,000	738,000	---
Rent, communications and utilities	6,598,000	8,226,000	+1,628,000
Printing and reproduction	997,000	966,000	-31,000
Other services	9,179,000	6,284,000	-2,895,000
Project contracts	12,356,000	13,456,000	+1,100,000
Supplies and materials	3,852,000	3,577,000	-275,000
Equipment	2,178,000	2,118,000	-60,000
Grants, subsidies and contributions	50,351,000	28,211,000	-22,140,000
Subtotal	152,786,000	133,313,000	-19,473,000
Less quarters and subsistence direct ...	-2,000	-2,000	---
Total obligations by object	152,784,000 1/	133,311,000	-19,473,000

1/ Includes $13,100,000 for Rat Control grants not authorized but requested in 1975 President's Budget; and excludes $440,000 of obligations from the 1973 released funds.

51-805 O - 75 -- 26

Significant Items in House and State Appropriations Committee Reports

Item	Action Taken or to be Taken
1975 House Report	
Lead-based Paint Poisoning Prevention in Children The Committee directed the Center for Disease Control to take the initiative in fiscal year 1975 to assist the other service programs of the Department, such as the neighborhood health centers, the maternal and child health programs, the family health centers, and Medicaid to incorporate routine lead screening as an integral part of the delivery of health care.	The Department continues to emphasize lead screening under the Early and Periodic Screening, diagnosis and Treatment Program (EPSDT), and in other federally assisted child health programs. Project grant assistance is being made by CDC to additional States as needed to develop or enhance their lead analysis laboratory capabilities. The Center has worked with SRS on technical guidelines for lead screening under the EPSDT program.
1975 House and Senate Report	
Occupational Health - Grants The Committee provided an increase of $2,000,000 for support of training grants.	The increase of $2,000,000 is being used to award approximately 25 training grants.
Occupational Health - Direct Operations The Committee provided an increase of 95 positions and $4,138,000 to support the additional staff, research, the development of criteria documents for occupational safety and health standards and for providing technical services to government, labor, and industry.	The increase of 95 positions and $4,138,000 is being used to staff various segments of the organization and to initiate research to reach a level of 26 criteria documents per year beginning in 1977.
1975 Senate Report The Committee recommends that the Department of Health, Education, and Welfare study the feasibility of assessing the need for technical assistance to State and local jurisdictions for the appropriate management of community health problems associated with natural and man-made disasters such as fires, floods, explosions of liquid and gaseous chemicals and related environmental conditions.	The study was completed and report was submitted in February 1975.

Authorizing Legislation

Legislation	1976 Authorization	1976 Appropriation Requested
Preventive Health Services Activity:		
Disease control		
Project Grants		
Sections 317(d)(2) and (3) of the Public Health Service Act.	1/	$4,960,000
Section 318(d)(2) of the Public Health Service Act.	1/	19,840,000
Lead-Based Paint Poisoning Prevention Act of 1973.	1/	3,500,000
Section 314(e) of the Public Health Service Act.	2/	5,410,000
Disease investigations, surveillance, and control		
Sections 301, 308, 311, 315, 322(e), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act.	Indefinite	43,429,000
Laboratory improvement		
Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act.	Indefinite	9,989,000
Health education		
Sections 301, 311, and 315 of the Public Health Service Act.	Indefinite	3,013,000
Occupational health		
Grants		
Sections 301 and 311 of the Public Health Service Act.	Indefinite	1,900,000
Direct operations		
Sections 301, 311, 327, and 328 of the Public Health Service Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.	Indefinite	30,281,000
Program management		
Sections 301, 308, 311, 314(e), 315, 317, 318, 322(e), 325, 327, and 328 of the Public Health Service Act; the Lead-Based Paint Poisoning Prevention Act of 1973; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.	Indefinite	10,989,000
Total 1976		133,311,000

1/ Section 317(d)(2) and (3) and Section 318(d)(2) of the Public Health Service Act and the Lead-Based Paint Poisoning Prevention Act of 1973 expire June 30, 1975.

2/ Section 314(e) of the Public Health Service Act expired June 30, 1974 - extension of legislation has been proposed.

Preventive Health Services

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1966	48,347,000	40,347,000	40,497,000	40,497,000
1967	44,230,000	44,220,000	44,220,000	44,220,000
1968	72,272,000	72,109,000	72,109,000	72,109,000
1969	63,407,000	62,144,000	62,144,000	62,144,000
1970	79,331,000	79,238,000	79,238,000	79,238,000
1971	82,138,000	82,538,000	90,600,000	84,538,000
1972	138,996,000	138,996,000	157,911,000	143,303,000
1973	139,980,000	159,972,000	223,970,000	159,970,000
1974	128,869,000	130,869,000	152,569,000	141,547,000
1975 considered	124,714,000	134,910,000	140,443,000	136,396,000
Pending	13,100,000			
1976	133,311,000			

Justification

Preventive Health Services

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	3,569	$63,438,000	3,508	$66,638,000	-61	+$3,200,000
Other expenses	---	89,346,000	---	66,673,000	---	-22,673,000
Total	3,569	152,784,000	3,508	133,311,000	-61	-19,473,000

General Statement

This appropriation provides support for the Center for Disease Control, one of the six agencies of the Public Health Service. This agency is the center of competence in the prevention and control of infectious diseases and certain other conditions. The agency's principal mission is to assist State and local health authorities and other health related organizations in stemming the spread of communicable diseases, in providing protection from some environmental hazards, and improving occupational safety and health. This mission is carried out in a multiphasic program which includes: (1) research, investigation, and evaluation of new methods of controlling or preventing diseases; (2) the provision of epidemic aid; (3) technical consultation and assistance in all aspects of communicable disease control; (4) active surveillance of disease and reporting on trends and developments; (5) laboratory improvement; (6) direction of a national health education program; and (7) occupational safety and health. In addition, this agency is charged with the responsibility for certain national health duties. These include the licensure of clinical laboratories engaged in interstate commerce and foreign quarantine activities aimed at preventing the introduction of disease into our Nation.

Hence, these programs are engaged in a wide spectrum of activities to improve the health of the people of this Nation. The Center for Disease Control is an organization devoted to public service through assistance, research, investigation, and only when necessary, regulation and enforcement.

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	2,645	$47,272,000	2,571	$49,032,000	-74	+$1,760,000
Other expenses	---	61,077,000	---	41,109,000	---	-19,968,000
Total	2,645	108,349,000	2,571	90,141,000	-74	-18,208,000
Subactivities:						
Project grants ..... Sections 317 and 318 of the Public Health Service Act. Lead-Based Paint Poisoning Prevention Act. Section 314(e) of the Public Health Service Act.	597	53,498,000	563	33,710,000	-34	-19,788,000
Disease investigations, surveillance, and control ..... Sections 301, 308, 311, 315, 322(c), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act.	1,503	42,251,000	1,503	43,429,000	---	+1,178,000
Laboratory improvement. Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act.	509	9,573,000	469	9,989,000	-40	+416,000
Health education ..... Sections 301, 311, and 315 of the Public Health Service Act.	36	3,027,000	36	3,013,000	---	-14,000
Total	2,645	108,349,000	2,571	90,141,000	-74	-18,208,000

1/ Section 317(d)(2) and (3) and Section 318(d)(2) of the Public Health Service Act and the Lead-Based Paint Poisoning Prevention Act of 1973 expire June 30, 1975.

2/ Section 314(e) of the Public Health Service Act expired June 30, 1974 - extension of legislation has been proposed.

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
PROJECT GRANTS						
Venereal diseases	505	$25,198,000	473	$19,840,000	-32	-$5,358,000
Immunization	82	6,200,000	80	4,960,000	-2	-1,240,000
Rat control	10	13,100,000	10	5,410,000	---	-7,690,000
Lead-based paint poisoning in children	---	9,000,000	---	3,500,000	---	-5,500,000

Venereal Diseases

Venereal diseases are still epidemic in the United States today. Control efforts have been mainly targeted to two diseases, syphilis and gonorrhea, which are highly communicable, which cause major medical disability if not treated, and for which control methods have been best developed. Because of the rapid spread of these diseases from area to area, control efforts must be applied nationally and on a uniform basis.

Project grant funds are used principally to support disease intervention activities at the State and local level. The primary focus of these programs is: (1)screening, by bacteriologic culture, high risk female populations for gonorrhea; (2) surveillance of syphilis through serologic screening of specific population segments; (3) application of the contact referral process to patients with infectious syphilis or gonorrhea; (4) educational efforts directed toward communicating pertinent venereal disease facts to people at risk with the objectives of preventing exposure or re-exposure to infection and of influencing infected individuals to seek early diagnosis and treatment; and (5) active involvement of the private medical community in all aspects of venereal disease control.

Federal funding for 1976 together with increased State and local support will assure continuation of the nationwide effort of States and localities to control the intra- and interstate spread of gonorrhea and syphilis. Emphasis will be placed upon strengthening intervention activities which are both medically and economically most effective in limiting the spread of disease through the early treatment of infected individuals, and upon assisting grantees in identifying other program resources to offset decreases in project grant funds. The overall level of gonorrhea screening should decline from the 8,000,000 females tested in 1975, as non-productive screening is discontinued. Greater emphasis will be placed upon the simultaneous treatment of steady sexual partners, relying more heavily on encouraging the patients themselves to notify their contacts, thus reducing the cost of gonorrhea contact follow-up while at the same time reducing the likelihood of immediate re-exposure to infection. Efforts also will be made to strengthen the epidmiologic management of individuals infected with syphilis to maximize the impact of contact referral and epidemiological treatment of contacts on case prevention.

During 1976, educational programs will be directed toward providing information about the venereal diseases to persons at high risk of acquiring infection, with the objective of reducing the probability of infection and re-infection. Additionally, educational programs will emphasize the involvement of

health care providers in all aspects of the venereal disease control effort. Physicians will be encouraged to diagnose properly, treat effectively, and involve patients in referring their sexual contacts to examination.

Primary and secondary syphilis ranks third among all reportable diseases, but for the first year since 1969, reported cases decreased slightly during 1974 (see table below). Recent data suggest that the trend for infectious syphilis has stabilized.

Late syphilis also declined during 1974, for the third consecutive year, with 33,465 cases reported. Reported cases of congenital syphilis in children under one year of age also decreased (15.2 percent) but these 302 cases are still nearly twice the number reported in 1957.

Gonorrhea currently ranks first among all reportable diseases. Although the long-term trend of gonorrhea incidence remains upward, the rate of increase was lower during 1974 than that experienced during 1973 (12.7 percent) and 1972 (15.1 percent).

	No. Reported Cases 1974	Change From 1973
Primary & Secondary Syphilis	24,728	-1.4%
Gonorrhea	874,161	+8.0%
Male	523,298	+3.7%
Female	350,863	+15.0%

Mass screening of female populations resulted in eight million women receiving bacteriologic culture for gonorrhea during 1974. Of those cultured, 4.3 percent were positive for gonorrhea and 90 percent of those who were positive were treated. As a result of these casefinding efforts, women with gonorrhea, previously undetected for long periods of time, are now being identified and cured. Because of this outreach effort, reported female cases are increasing at a higher rate than males who generally, because of acute symptoms, voluntarily seek diagnosis. The fact that reported cases of male gonorrhea rose only 3.7 percent during 1974 suggests that the rate of transmission is being curtailed.

Immunization

Safe and effective vaccines which can prevent and control outbreaks of many communicable diseases are now available. During 1976, immunization grants will be awarded to official health agencies which serve all areas of the Nation. These grants will continue to assist recipients in developing and refining their capabilities in carrying out comprehensive immunization programs. However, grantees will give emphasis during 1976 to the conduct of effective assessment of immunity levels among important sub-populations, on implementing sensitive surveillance systems to detect disease outbreaks, and on developing an effective response mechanism when outbreaks of disease are threatened or when inadequately immunized population groups are identified. States and localities will be expected to support an increased share of routine vaccine costs and vaccine delivery systems from non-project grant funds. The CDC will assist States and localities in identifying and obtaining non-project grant resources.

During 1975, immunization efforts are being directed toward identifying and immunizing the large number of preschool-age children inadequately immunized against the vaccine preventable diseases and to reduce further the incidence of disease in this age group. The results of the 1974 United States

Immunization Survey show an increase in children in the 1-4 year age group who are immune to all of the vaccine preventable diseases; the same is true for the 5-9 year age group.

In the preschool-age group, the 10-year steady decline in poliomyelitis immunization levels has been reversed. Measles and rubella immunization levels are higher than at any previous time since the licensure of these vaccines, and the disparity between the children receiving care in public health clinics compared to private medical practice has been narrowed.

In calendar year 1974, there were only 22,085 cases of measles, 11,836 cases of rubella, and 5 cases of paralytic polio reported in the United States. The reported cases of rubella in 1974 represent a 72 percent decline compared to the average for the past 5 years. In fact, fewer cases of polio, measles, and rubella have been reported during 1974 than in any year since reporting began. Also, reported diphtheria, pertussis, and tetanus morbidity remained low (257, 1,758 and 94 respectively).

Rat Control

Project grants will be awarded to urban areas to reduce rat infestations and to insure the maintenance of rat control programs by local governments and through voluntary community action. Grants are made with built-in reductions in Federal support, and with requirements designed to insure neighborhood, as well as local government, assumption of ongoing rat control responsibility.

The existing technology for reducing rat infestations has been successfully demonstrated, and local areas are beginning to demonstrate the capability to participate fully in maintaining control once it has been established. Emphasis in 1976 will be placed on strengthening the surveillance and program evaluation capabilities of local areas which have turned the corner in eliminating infestations. An additional 10 percent of the existing target area should reach a control maintenance level during 1976.

Sixty percent of the 45,000 blocks (approximately 7 million people) in the existing target area will reach a maintenance level during the year, providing an opportunity to assist other cities with a demonstrated critical need for an intensified control effort. By the end of 1975, it is expected that 59 communities will have developed rat control programs supported in varying degrees through 41 project grants. This is a marked increase since its inception in 1969, when only 15 grants served 20 communities. This initial assistance has been successful in getting programs underway; therefore, it is possible in 1976 to reduce the level of federal support.

Lead-Based Paint Poisoning in Children

Project grants for the control of lead-based paint poisoning in children are made to stimulate screening, diagnosis, treatment and the prevention of childhood lead poisoning. The grants are designed to increase local and State revenue support in identifying and, as necessary, treating children before serious effects of lead poisoning occur. The abatement of environmental lead hazards in residential dwellings of affected children is required, although costs for these actions are supported by non-project grant funds except in emergency situations. Development of centralized State laboratory capability in specimen analysis and proficiency testing is also supported.

During 1976, it is estimated that 300,000 children will be tested in 35-40 project communities. Emphasis will be placed on using protoporphyrin testing as the primary screening tool, in lieu of blood-lead procedures, in order to

resolve contamination problems which have plagued earlier programs and to provide a more accurate indication of children whose lead intake is reaching abnormal levels and who will require further medical evaluation. Appropriate hazard abatement activities will be undertaken in a minimum of 70 percent of the dwelling units where lead-based paint has been identified as the source of a child's lead exposure.

Seventy-seven lead screening projects have been funded since the inception of the program in 1972. In 1975, 490,000 children will be screened. This represents an increase of 32 percent over 1974. Twenty-eight State laboratories were also funded in 1974 to begin providing direct services, proficiency testing and consultation to public and private laboratories throughout the State. With the increased State laboratory capabilities and the expansion of screening efforts programs, the practicality of lead poisoning programs has been amply demonstrated. On this basis Federal grant support is being reduced in 1976.

The decrease of $19,788,000 and 34 positions includes a decrease of $5,358,000 and 32 positions for venereal disease control, $1,240,000 and 2 positions for immunization, $7,690,000 for rat control, and $5,500,000 for lead-based paint poisoning prevention. The reduction in venereal disease and immunization project grants results from expectation that State and local funding will be increased. The rat control project grants reduction will be accomplished by terminating grant assistance to communities after the sixth year. The reduction in lead-based paint poisoning prevention will be accomplished by terminating low yield projects and by (a) encouraging early diagnosis and treatment under medicaid and other health service delivery programs, and (b) utilizing the strengthened capability of State health laboratories to perform blood-lead analysis.

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease investigations, surveillance, and control	1,503	$42,251,000	1,503	$43,429,000	---	+$1,178,000

The programs of the Center for Disease Control that are supported under this budget activity include a wide variety of public health functions aimed at control of a multitude of diseases and conditions. These operations represent a major aspect of the preventive health activities of the Public Health Service. The various activities have been broadly categorized according to the primary emphasis of the preventive health activities as governed by factors such as the state of the art and the nature of the health problem. The scientific and technical competence and facilities which are devoted to this work represent a valuable national health resource.

Investigations

The Center is concentrating on investigations or developmental research to gain needed knowledge of the etiology of diseases or to develop new or improved control measures. The investigations are carried out in both the laboratory and the field. In its specialty laboratories that are located in the Center Headquarters in Atlanta, Georgia, and in five field locations, CDC is carrying out work on infectious, and certain non-infectious diseases and conditions.

Viral Diseases

An investigation of a community outbreak of hepatitis A resulted in recovery of viral particles in stools which were shown by immune electron microscopy to be the infectious agent of the disease. This breakthrough paves the way for the development of serologic techniques that can be used to perform epidemiologic studies of hepatitis A on a national basis. Additional confirmatory studies have been conducted and work on the biophysical characterization of hepatitis A is underway. In addition, this recovery of the hepatitis A virus is an early step in the development of a vaccine.

Also, the Center investigated a large outbreak of hepatitis B among patients who received plasma protein fraction (PPF) originating from a single manufacturer. Studies were instituted and will be ongoing in 1976 to determine whether administration of PPF in general to individuals results in a greater risk of hepatitis B infection.

CDC continues to have the world's most proficient, high security, diagnostic facility for diseases caused by new and extremely pathogenic micro-organisms. The facility is currently being expanded to permit an even broader scope of research and service. During the past year, the pathogenesis of Lassa fever was elucidated in the laboratory. Other studies in the laboratory showed that a species of African wild rat is the probable natural host, undergoes long-lasting infections and sheds highly infective virus in its excretions. Inactivated Lassa antigens were prepared and distributed to workers in India, Africa, and the U.S.S.R. to permit them to safely conduct serologic surveys for infection in their areas. Immunologic studies will now be conducted to determine the possibility of producing and using protective sera.

In 1976, as the new maximum security facilities become operable, research and diagnostic services will be extended. Highly specific inactivated antigens will be prepared for Marburg and Herpes B viruses as well as Lassa, and will be distributed as required. The Center will provide laboratory support for investigations of outbreaks of any deadly diseases, no matter where in the world they occur.

During 1975, both field and laboratory epidemic aid services were provided during outbreaks of St. Louis virus - encephalitis in Tennessee and Mississippi and during an epidemic of California virus - encephalitis in Missouri. As part of the activities of the World Health Organization Regional Reference Center for Arbovirus activities, more than 95 virus isolates submitted by collaborating laboratories in six States and four foreign countries were identified and characterized.

During 1975, the CDC developed mosquito inoculation technique for the rapid sensitive and economical isolation and identification of dengue viruses which facilitated the isolation of twenty different viruses on the island of Puerto Rico. In addition, a dengue outbreak was detected in one community and sporadic cases detected in three other cities with populations of 175,000 through a dengue surveillance system. Control activities then were initiated by the Puerto Rico Health Department to prevent the spread of disease. Major applied research objectives include intensive investigations of the pathogenesis, immunology, physiochemistry, and vector relationships of Western equine encephalitis (WEE), Venezuelan equine encephalitis (VEE), California encephalitis, Colorado Tick fever (CTF), and other arbovirus diseases. During 1976, the Center will continue to aid local, State, and Federal agencies in mosquito-borne disease outbreaks. Primary emphasis will be placed upon developing effective surveillance programs for St. Louis encephalitis in areas of the Southeast affected in 1974.

Epidemiological and ecological investigations of other viral diseases of public health importance will be continued. These diseases and the areas they concern include CTF in the Rocky Mountain National Park, VEE in Ecuador, and WEE in the Western United States. The WHO reference Center activities will be continued and expanded, with emphasis on developing a worldwide capability in the identification and characterization of arboviruses.

Also in 1976, the Center will focus on improved understanding of the pathogenesis of dengue hemorrhagic fever, the more serious, often fatal disease associated with dengue virus. In addition, methodology for detecting dengue virus in Aedes aegypti mosquitoes by fluorescent antibody techniques will be improved so that the presence of virus in the environment can be detected more readily prior to actual disease outbreaks.

Bacterial Diseases

Investigation of bacterial diseases has been concentrated on further defining the etiology of the diseases and improved diagnostic techniques. The increase in botulism has led to the development of better and quicker diagnostic methods. Current data indicate that examination of intestinal contents is more sensitive than bioassay of the patient's serum for toxin. In 1976, a radioimmunoassay technique will be developed and evaluated for the detection of botulinal toxin in serum and other materials and FA conjugates for identification of C. botulinum in various specimens will be explored.

The strain of typhoid bacillus involved in the widespread epidemic in Mexico in 1972-73 has received considerable attention because it was initially a chloramphenicol resistant strain and presented a therapeutic problem. Several

hundred strains from Mexico and a number of those isolated from U. S. travelers have been studied by phage typing and antibiotic patterns to determine the epidemiology of the outbreak.

Studies will be initiated to determine the mechanism by which the loss of antibiotic resistance occurred and if the same strain is still involved or if the epidemic strain has been replaced by nonresistant strain(s) in the human population.

Parasitic Diseases

A long-term community-based study of schistosomiasis will be continued at the field facility in San Juan, Puerto Rico. As a part of this study, parasitologic examinations and serologic tests were performed, and intensive snail control and health education was provided. A new serologic test, an enzyme link in immunoabsorbent assay (ELISA), has been proved to be most sensitive and specific, and the procedure is being evaluated for the diagnosis of schistosomiasis and other parasitic diseases.

Seroepidemiologic studies will continue on malaria, once again the world's greatest disease problem. Studies will be designed to further standardize the indirect hemagglutination test for malaria, to develop purified antigens, and to evaluate methodology directed toward the use of seroepidemiologic tests under field conditions. The purpose of the seroepidemiologic studies in malaria is to develop methodology for a more efficient identification of high risk populations. When this method has been perfected, it will greatly facilitate control measures. Toward this end, studies will be carried out in Nigeria, Mexico, Costa Rica, and Bangladesh in collaboration with WHO.

Fungal Diseases

Fungal diseases pose important public health problems, since pathogenic fungi can attack all organs of the body. The clinical picture of patients with mycotic diseases varies considerably and closely simulates that of other diseases. Therefore, the diagnosis of fungal diseases is virtually impossible to establish on clinical grounds, and highly sophisticated laboratory tests are required. Since most hospitals and health departments lack medical mycological competency, the Center provides a national diagnostic service. The diagnostic work load has continued to increase in number of specimens processed and number of tests provided. Efforts have also been directed to developing more accurate and rapid tests for the diagnosis of fungal diseases and for monitoring patients' responses to therapy. The diagnosis of blastomycosis, a serious lung disease, was improved by supplementing the complement fixation test now being used with a more specific and sensitive immunodiffusion test. Further, two new rapid tests for sporotrichosis and histoplasmosis were developed. To help physicians select the proper chemotherapeutic agent and dosage, the Center initiated a service designed to test the sensitivity of fungal isolates to various antifungal drugs and rapidly report this back to the physicians.

Noninfectious Diseases

During 1975, investigative activity has been undertaken in collaboration with other health agencies. Work continues on analytic studies concerned with: (a) the potential relationship between infectious mononucleosis and later development of cancer; (b) the concept that interpersonal contacts among patients

with leukemia/lymphoma, particularly Hodgkin's disease, may be a factor in the epidemiology of such diseases; and (c) the combined laboratory/epidemiologic search for antibody against feline leukemia virus among persons exposed intimately to cats shedding such viruses.

Three major epidemiological studies in relation to vinyl chloride (VC) are underway. These studies include: (a) data collection concerning illness (especially cancer) among cohorts of VC polymerization workers; (b) medical screening of some 500 VC polymerization and rubber workers at a plant in Pottstown, Pennsylvania; and (c) surveillance of recent cases of hepatic hemangiosarcoma in the U. S. with respect to possible occupational or environmental exposure to VC and other suspected hepatic carcinogens. Environmental hazards investigations not connected with cancer were also conducted, particularly exposure to lead among populations living near lead smelters.

Projected work in 1976 will involve continuation of studies related to vinyl chloride and to lead. Additional projects will be developed: (a) a cohort study concerning cancer mortality among U.S. workers in the manufacture of polychlorinated biphenyls, and (b) study of childhood cancer in relation to arsenic levels near a smelter.

Programs in the area of clinical immunology also will be emphasized in 1976. A program devoted to the serologic diagnosis of malignant diseases will be initiated. Immunologic studies of and urine specimens from a wide variety of malignant diseases will be conducted and "computerized".

Surveillance

Disease surveillance activities of the Center for Disease Control relate to diseases of public health significance occurring in this country or presenting a threat of introduction into this country.

The broad objective is to improve disease surveillance at all levels--Federal, State, and local. Rapid reporting of diseases, analysis of trends, and prompt epidemiologic investigation of outbreaks constitute a comprehensive surveillance program.

Disease trends are analyzed on a weekly basis in order to identify outbreaks of potential significance so that appropriate intervention actions can be taken. Surveillance reports for 30 diseases were issued in 1974. These reports are widely distributed (approximate average circulation is 5,000 for each report), used and quoted nationally and internationally, providing the basis for public health control and training activities.

The main component of the Center's surveillance program is the Epidemic Intelligence Service (EIS). In addition to headquarters staff, EIS officers are located in 41 State and city health departments throughout the United States.

In 1974, there were 110 epidemic aid missions and 1,250 epidemic/outbreak investigations conducted. Of particular significance were the following: (1) assistance was given the government of Brazil (under the auspices of Pan American Health Organization) in a large-scale outbreak in Sao Paulo of group C meningitis, a vaccine for which was evaluated by the Center in 1972; (2) changing patterns in food preparation resulted in 18 outbreaks of botulism (compared to only 9 in the previous year); (3) outbreaks of shigellosis and salmonellosis aboard 2 passenger cruise ships led to a large survey (2,445 cruises in 38 ships over 20 months) of gastrointestinal illness; significant levels of illness revealed

resulted in CDC's issuance to the cruise ship industry of food and water handling guidelines and regulations for the reporting of shipboard diarrheal illness; (4) investigation of nosocomial (hospital acquired) infections outbreaks due respectively to contaminated albumin and the use of a particular brand of plastic intraveneous catheter, along with follow-up surveillance of those products on a national basis, resulted in their subsequent recall and rectification.

Approximately 1,250 separate disease outbreaks will be investigated during 1975 in collaboration with local health workers, and an estimated 1,500 such investigations will be conducted during 1976. Also, 8 additional locations for EIS field assignments are planned for 1976, so that the CDC will have direct liaison with 35 State and 7 metropolitan areas through EIS officers stationed there.

In 1975, the Center processed 131,000 of the most difficult reference diagnostic specimens from throughout the Nation. This work represented tests which were either unavailable elsewhere or were too difficult and expensive to be provided in the State or local health department laboratories. Approximately 1.7 million different determinations were made on these specimens. For 1976, a modest growth is expected in this area because different tests will be added and others deleted as competency for providing the services at the State and local level expands. Epidemiological laboratory support will be provided as disease outbreaks occur.

More specifically, the areas of special emphasis in 1975 have included nosocomial infections (infections developed in hospitals), influenza, birth defects, and smallpox.

Nosocomial Infections

The National Nosocomial Infections Study (NNIS) is one of the more important surveillance programs of the Center. NNIS data has been increasingly used for evaluation of important public health problems, including investigation and ultimate recall of nationally distributed contaminated patient-care products; study of the incidence and mortality for gram-negative bacteremia for a Senate Subcommittee; and evaluation of nursery-acquired infections after the discontinuation of hexachlorophene. Since NNIS data will be used for similar purposes in the future, improvement of the quality of NNIS data continues to be a priority objective of the Center.

A pilot study of rapid telephone reporting of nosocomial infections proved sufficiently effective to warrant the institution of such a system in all participating hospitals. Infection control personnel are now dictating surveillance reports to CDC on a daily basis, and these reports are directly coded for computer analysis. A 3-month feedback lag characteristic of the former system has been reduced to 2 weeks.

Influenza

The special influenza surveillance program established in 1974 was continued in 1975, and included the collection and analysis of influenza morbidity from approximately 70 metropolitan areas throughout the country. This information, coupled with the regular mortality assessment, served to accurately monitor influenza A and B activity in the winter of 1974; it will continue to be an apparently accurate monitor during the winter of 1975. Of particular import during the surveillance program was the incorporation of surveillance of Reye's Syndrome, a severe brain disease of children. Over 400 cases (far more than ever reported before) were reported during the winter

of 1974, and the data provided significant clinical and epidemiological factors heretofore not well appreciated. It appears that Reye's Syndrome is closely related to influenza B infections and can be expected to occur after influenza B epidemics. Expected incidence of Reye's Syndrome was determined to be approximately 1 case for every 1,700 to 2,200 cases of influenza B in children.

To improve influenza surveillance, the National Center for Health Statistics (NCHS) will provide CDC with weekly morbidity data on respiratory disease from a sample of the United States population as a supplement to regular ongoing morbidity and mortality indices. Intensive case-by-case reports of influenza and selected culturing for viral isolates will be performed by physicians at Kaiser Foundation Hospitals in Portland, Oregon, and reported weekly to CDC. Coupled with NCHS data for mortality statistics from Portland, the Oregon State Influenza Surveillance Programs, and other indices of influenza, the Kaiser data should provide CDC with an excellent evaluative foundation for comparing and improving various surveillance systems.

The CDC's WHO Collaborating Center for Influenza has continued to work closely with over 50 collaborating laboratories in the Western Hemisphere and elsewhere to provide immediate reference diagnostic service and to evaluate possible antigenic drift in current flu strains. The influenza surveillance network has been, and is being, maintained at a level capable of detecting new influenza viruses when and where they occur. The information provided by the network forms the basis for influenza vaccine formulation throughout the world.

A vaccine trial study was completed during 1975 for oral attenuated influenza vaccine in a population of 400 university students. This trial demonstrated the vaccine's immunogenicity, safety, and acceptability.

In cooperation with the State of Colorado, a large study (in 300 nursing homes with 13,000 persons) will be conducted to determine vaccine efficacy in the high risk elderly population. Continued investigation of live attenuated influenza vaccines will be performed in adult populations comparing various live attenuated vaccines. Prospective studies will be established to monitor newly licensed influenza vaccines as they become available and are used.

Birth Defects

Surveillance of birth defects, acute morbidity, and physical growth, continued in 1974-75. Selected areas provided data for monitoring defect case occurrence and for descriptive and analytic studies of particular birth defects. During the same time, two new projects providing birth defects data on a national level were begun: (1) the Birth Defects Monitoring Program, a computerized system which provides for monitoring of defect cases occurring in the approximately 1 million infants born annually in hospitals participating in the data system of the Commission on Professional and Hospital Activities (a project in collaboration with National Institute of Child Health and Human Development); (2) a national surveillance of Rh hemolytic disease of the newborn, which affects some 13,000 infants annually, causing an estimated 1,300 infant and fetal deaths each year.

Another area of surveillance emphasis for 1975-76 will be the organization and implementation in the metropolitan Atlanta area of a community-based service of prenatal diagnosis of Down's Syndrome (Mongolism) for pregnant women age 40 and above; an attempt will be made to evaluate the utilization of such services for possible public health application on a general scale.

Smallpox

Only three countries in the world, India, Bangladesh, and Ethiopia, continue to have endemic smallpox, down from 29 at the beginning of the Global Eradication Program in 1967. West and Central Africa have remained free of smallpox, with the last case occurring in May 1970. The Western Hemisphere is now completely free of smallpox, with the last case occurring in Brazil in early 1971. Worldwide eradication by 1976, the original target, still appears realistic. The successful culmination of the Smallpox Eradication Program will be the first time in recorded history that man has succeeded in eradicating any disease.

The Center continues to play a key role in the worldwide smallpox eradication program by providing staff to WHO to serve in the infected areas and by serving as the main diagnostic laboratory. As eradication draws nearer, prompt and accurate diagnosis of each suspect case becomes even more critical.

1976 Objectives

In 1976, following the selection of study and control hospitals representative of the entire population of U.S. short stay hospitals, a pilot study will be conducted in a subsample of hospitals to test the accuracy of nosocomial data collection and procedures. Following successful completion of the pilot studies, teams of CDC data collectors will visit all study and control hospitals to document nosocomial infection rates before and after the implementation of surveillance and control programs. Besides valuable insights regarding hospital infection control, this project should provide accurate estimates of economic benefits to be expected by implementation of infection surveillance control programs on a national basis.

Nationwide surveillance of viral hepatitis will be expanded in 1976. Surveys will be mounted to determine the occupational risk of hepatitis for dental practitioners and hospital employees. Continued study of high risk areas in the hospital environment, especially renal dialysis units, hematology-onocology units, clinical laboratories, and blood banks will be maintained to permit formulation of appropriate preventive and control measures.

Control

CDC has a two-fold responsibility in the prevention and control of diseases. On the one hand the Center is concerned with carrying out Federal responsibilities for preventing the interstate spread of disease as well as preventing the importation of disease from abroad. Additionally, CDC provides assistance to State and communities in the conduct of their public health programs. Close collaborative relationships are maintained between CDC and official health agencies at the State and local level since the effective disease control involves an interdependence among the various levels of government. The CDC activities include operational research, development of control strategies, and technical assistance, as well as minimal regulatory operations at ports of entry.

Venereal Diseases

As the nationwide program to control gonorrhea became fully operational in 1974, major efforts during 1975 were directed at refining program strategies and techniques. Technical assistance was devoted to reviewing program progress in the implementation of new strategies and the development of quality control activities related to the laboratory aspects of the gonorrhea screening program.

51-805 O - 75 -- 27

For more than 15 years, the gonococci have been gradually developing resistance to penicillin and other antibiotics. In order to monitor trends in antibiotic resistance and to evaluate the efficacy of treatment, a national therapy monitoring network has been established in 9 treatment centers. This effort includes: the evaluation of existing and new antibiotics - alone and in combination; the study of the mode of action, toxicity, and the development of resistance to certain antibiotics; a monitoring system to detect the emergence of resistant strains; and the development of improved assay methods for antibiotic susceptibility and blood levels. In vitro resistance to penicillin does not appear to have increased over the past two years as it had previously. This activity will continue to be emphasized throughout 1976.

Previous experiments to confirm data on the ability to effectively immunize chimpanzees with killed suspensions of Neisseria gonorrhoeae have been successfully repeated. This work has been extended, and other groups of chimpanzees have been immunized with two different purified fractions. A protective antibody response was demonstrated with both cell fractions. During 1976, further attempts to purify the fractions and confirm the findings in smaller animals will be made.

Efforts to develop a serologic test that can be used effectively to screen populations for the presence of gonorrhea have not been successful in that these tests do not possess the desired level of sensitivity and specificity.

The major direction in 1976 will be to further refine gonorrhea control strategies with emphasis on the cost effectiveness of procedures and programs in interrupting the spread of disease. Special efforts will be made to strengthen the communication system for epidemiologic information vital to control the interstate transmission of disease.

A basic control mode for gonorrhea is currently under development. The development process of this model has permitted venereal disease control programs to more clearly focus on unresolved or poorly understood facets of gonorrhea epidemiology. When completed, the model will serve as a management guide and tool to direct the best use of resources for maximum disease control results.

The major stumbling block to more definitive work on Treponema pallidum, the cause of syphilis in man, has been the inability to cultivate the organism in an in vitro system. Present methods of cultivation are limited to testicular inoculation of rabbits. Research with a subcutaneously implanted chamber in rabbits indicates that the fluid within the chamber will support the growth of T. pallidum. In addition, a semisynthetic medium has also been developed which is capable of maintaining viability and virulence for at least 7 days. Absolute increase in numbers is believed to occur and is to be determined with future experiments. This research may lead to the development of a system that will support the growth of T. pallidum in the absence of animal tissue cells.

Rapidly accumulating data indicate that other sexually transmitted diseases are growing in importance and require further attention and definition. The three most important of these diseases are nonspecific urethritis, genital herpes, and trichomoniasis. The Center is beginning to assess their public health significance and to define questions related to the diagnosis, medical management and control of these diseases.

Tuberculosis

In calendar year 1973 there were 30,998 cases of reported tuberculosis. For 1974, the provisional figure is approximately 30,273 cases, a decline of 2.3 percent as compared with an average yearly decline of 6 percent for the years 1967-1973. In order to accelerate the decline in tuberculosis morbidity, the Center is working closely with State and local health agencies in increasing the efficiency of existing control methods, insuring that these methods are implemented through the health care delivery system of the Nation, and seeking even better methods of control for the future. As a result, average length of stay in hospitals has been reduced 25 percent since 1970, unnecessary and costly post-treatment follow-up has been curtailed in the majority of tuberculosis control programs, and unproductive mass screening activities have been greatly reduced.

In spite of these advances much needs to be done to improve control programs. The newly developed method by which sputum specimens could be mailed to a central laboratory from the point of collection was evaluated and found to provide satisfactory results when compared to the conventional on-site culture techniques. This method is now being used by several State health department laboratories, and its usage will be expanded during 1976.

Over 215,000 doses of skin testing antigens were distributed to 200 physician-investigators. These antigens, which are not available commercially, are an adjunct in the differential diagnosis of tuberculosis and related disease. They are also used in epidemiological surveys.

The Center also conducts operational research activities to refine diagnostic procedures for identification of persons with tuberculous infection or disease and developing effective well-tolerated treatment and prevention regimens of shorter duration: results of PHS studies demonstrate the effectiveness of the newer drug Rifampin for disease treatment; and early results of a cooperative international study suggests that 6 months of preventive therapy is as effective as the presently recommended period of 12 months. Research activities will also include an effort to define who is at the greatest risk of developing tuberculosis by initiating studies to determine the significance of various immunological responses.

During 1976, the role of isoniazid as a potential mutagen will be investigated. The mode of action of ethambutol as an antituberculous drug will be studied, and investigations on the genetics of multiple drug resistance in mycobacteria will be continued. Development of FA procedures applicable to mycobacteriology will be completed.

Immunization Activities

The Center provides national leadership, consultation, and technical assistance to State, local, and other Federal health agencies conducting immunization programs. This may be by evaluating local immunization programs, assessing the immune status and the appropriate use of vaccines, or by coordinating a nationwide educational and motivational effort to identify and insure the immunization of large numbers of unprotected preschool age children. Close and effective collaborative working relationships with appropriate Federal agencies is maintained to insure the inclusion of immunization practice standards in guidelines and regulations related to vaccine-preventable disease practices managed by these offices.

During 1974 and 1975, intensive motivational and educational efforts called Immunization Action Month (IAM) were coordinated by the Center to try to reduce declining trends in immunization. These efforts were directed at both parents and health officials, including physicians in both the public and private sectors. Data from the 1974 United States Immunization Survey show an increase in children in the 1-4 and 5-9 year age groups who are immune to all of the vaccine preventable diseases. The 10-year steady decline in poliomyelitis immunization was reversed. During 1976, the Center will continue to refine immunization control strategies with special emphasis on the assessment of immunity status of preschool age and school-entering children, the conduct of educational and motivational activities, the surveillance of morbidity trends and immunization coverage, and outbreak control.

A long-term study of the duration of the effectiveness of live rubella vaccines was begun in 1969 in 5,000 Hawaiian children. HI antibody levels and incidences of active rubella infection are being determined annually. This is the only study of its kind, and will be continued as long as practicable to provide invaluable information on the duration of immunity.

Environmental Health

The Center also provides technical assistance to State and local health agencies and private nonprofit organizations in the areas of urban rat control and lead-based paint poisoning prevention. Emphasis in 1975 and 1976 is on improving and evaluating lead analysis procedures and on upgrading and expanding State level laboratory capabilities in lead analysis. These laboratories will provide direct services in support of lead screening programs, including screening under the Early and Periodic Screening, Diagnosis, and Treatment Programs, and will also provide technical assistance and proficiency testing services to other laboratories in the State.

The Center is developing a suggested State statute and regulations pertaining to youth camps throughout the Nation. These materials are being prepared in cooperation with national camping organizations. Suggested State regulations are being developed for residential, day, troop, trip, travel, and primitive camps. The regulations will provide specific coverage for common phases of camp operation directly affecting the health and safety of the youth. In addition, health and safety standards for high-risk activities in youth camps are currently being developed. These standards will be concerned with events such as rock climbing, aquatic activities, scuba diving, horseback riding, white water canoeing, arts and crafts, and firearms and archery control. Regulations will be made available to State regulatory agencies and other interested groups following completion of their development. A number of environmental health related manuals have been revised and updated to meet program needs and to fill requests from government and non-government sources.

Quarantine Operations

Inspectional procedures established at major international U.S. airports will continue in 1976 to be adapted and improved so that a continued high level of protection of the public health can be maintained with reduced manpower resources. Cooperation elicited from other Federal inspectional agencies and representatives of the airline industry has allowed the reallocation of PHS personnel necessary to maintain continuous surveillance of signs and symptoms of disease of public health significance among arriving passengers. Reports of illness received on aircraft and vessels (269 during the past year) are investigated, specimens are collected for laboratory analysis, and medical consultation is provided.

Proposed changes in regulations in 1975-76 will permit further implementation of procedures and methods necessary to provide a scientifically based service to the public, at the same time facilitating international travel. Regulations regarding aircraft disinsection are in the process of being revised to include two additional aerosols approved for such use. Surveillance and control of the Aedes aegypti mosquito at selected airports and ports of entry in compliance with WHO International Health Regulations continued in 1974 resulting in 68 inspections and the identification of Aedes aegypti at 11 sites. Procedures for surveillance and control of Aedes aegypti will continue to be refined in 1976.

The increase of $1,178,000 in 1976 includes $2,094,000 for built-in increases such as annualization of positions new in 1975; annualization of pay raises; within grade increases; one extra day of pay; annualization of Federal Employees Health Benefits; Office of Federal Employees Compensation; postage, utility, and FTS; training requirements of OMB Circular A-48; safety requirements of PL 91-596, increased maintenance cost of Clifton Road building complex, Department Working Capital Fund, and Public Health Service Service and Supply Fund; and a program decrease of $916,000 which results from the change in policy which requires State, local, and other organizations to pay for short-term health training provided by the Center for Disease Control.

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Laboratory improvement ...	509	$9,573,000	469	$9,989,000	-40	+$416,000

The Center for Disease Control administers a comprehensive effort to improve clinical laboratories in the United States by conducting research and development programs for the evaluation, standardization, and effective application of laboratory methodology. It operates a national reference laboratory service in the disciplines of bacteriology, mycology, virology, parasitology, clinical chemistry, hematology, and pathology. It conducts extensive field and laboratory investigations on arboviral diseases and on diseases peculiar to the Caribbean area. The CDC also provides assistance to laboratories of States, large municipalities, and, under the auspices of the WHO, foreign countries in the form of consultation, laboratory management service, and dissemination of new and/or improved procedures. In cooperation with the Food and Drug Administration (FDA), the CDC develops performance standards for commercial products used in clinical laboratories for the diagnosis of human diseases. Under the authority of the Clinical Laboratories Improvement Act of 1967 (CLIA), CDC is responsible for licensing and testing the proficiency of laboratories engaged in interstate commerce. In addition, it collaborates closely and extensively with the Social Security Administration (SSA) in developing uniform high standards for evaluating Medicare and CLIA laboratories. Other functions include (1) conducting a long-term postdoctoral residency program in microbiology to develop broad competency in supervisory health laboratory personnel; (2) producing and distributing microbiological reference reagents for standardization and quality control purposes; (3) evaluating commercial reagents; and (4) distributing experimental vaccines and special immune globulins.

The CDC, by administering the national laboratory improvement program, continues to be the lead Federal agency concerned with upgrading the Nation's clinical and public health laboratories. The Center assists, and cooperates with, all State health agencies and private professional associations in achieving the broadest possible acceptance and application of high, uniform standards which are, in turn, designed to assure accurate and reproducible diagnostic laboratory test results. Emphasis continues on the development of laboratory technology in three major areas: (1) analytical methods, (2) calibration and control materials of high quality, and (3) procedures for quality assessment and control. Additionally, extensive effort continues to be directed to the transfer of technology to laboratorians whose responsibility it is to provide accurate results for use by physicians in managing patients. This technology transfer is achieved through technical publications, presentations at professional meetings, training, and consultation.

Normal program growth is expected as the number of clinical laboratories entering interstate commerce increases. By the end of 1976, the number of laboratories approved for interstate commerce by CDC and CDC-approved programs will total 960, representing approximately a 10 percent increase over the figure for the previous fiscal year. Special programs requested by the Indian Health Service, the Job Corps of the Department of Labor (DOL), and the epidemiological

programs related to blood lead, drugs of abuse, and gonorrhea are expected to increase the total number of participants in the CDC and CDC-approved proficiency testing programs to 2,900 of the 14,000 clinical laboratories in the Nation. The number of laboratories requesting exemption from all evaluation because of processing fewer than 100 specimens per category per year will increase by 11 percent, to 750.

All current evaluation and licensing activities are expected to continue in response to applications from laboratories conducting business in interstate commerce. The introduction of new tests, however, will necessitate additions to the battery of proficiency testing samples and to criteria for internal quality control programs. The use of kits in lieu of conventional methods will require additional quality control standards and proficiency testing methods. The addition in 1976 of proficiency tests for those procedures not currently provided will increase the number of tests for constituents from 262,000 to 277,000 per year; the number of samples sent to participating laboratories will not increase significantly, because more constituents will be contained in each sample.

The CDC program will continue to respond to requests from numerous State agencies for review of their laboratory evaluation programs. The objective is to develop programs comparable to the CDC program so that the States can assume responsibility for evaluating interstate laboratories within their own areas. CDC will evaluate, consult, advise, and then monitor the efficacy and objectivity of the State programs. An estimated five additional State programs can be evaluated during 1976.

During 1975, laboratory management consultation activities included the presentation of 10 three-day workshops on medical laboratory management for the Association of State and Territorial Public Health Laboratory Directors, 12 special studies on management procedures and programs in State public health laboratories, and 60 laboratory facilities consultations emphasizing flexible, efficient, and economical use of costly State and local diagnostic facilities. During 1976, further consultations will be provided in this area. In addition, research will be initiated to identify those laboratory tests which have the greatest adverse effect on the patient when errors occur. The results will aid both public health and clinical laboratories in the rational allocation of resources for laboratory improvement efforts.

In 1975, the CDC continued its involvement in commercial diagnostic products, both in its own voluntary premarket evaluation program and in cooperation with the FDA in developing performance standards for commercially available in vitro diagnostic products. Specifications and evaluation methods for chlamydial, mycoplasmal, rickettsial, and viral reagents were published in 1975. Standards for bacterial, fungal, and parasitic reagents will be published late in 1975 or early 1976. These volumes are distributed to approximately 500 producers and consumers of these reagents nationally and internationally.

In addition, CDC evaluated 3,600 lots of commercial reagents. The percentage of satisfactory commercial reagents fluctuates, depending on the types of reagents evaluated during a time period. With well established products and experienced manufacturers, 80 to 85 percent of voluntarily submitted premarket products are satisfactory. The percentage of satisfactory commercial venereal disease (VD) media evaluated changed dramatically from 74 percent satisfactory in 1974 to 88 percent satisfactory in 1975.

Selected products purchased from the open market are evaluated to determine if they meet CDC performance specifications. Although the selection is not totally unbiased, only 60 to 70 percent of these are satisfactory. When

unsatisfactory products are identified, the producer and FDA are notified. The CDC product evaluation program is complementary to the FDA's regulatory program. Also, the Center evaluates specific lots submitted by FDA to determine if they are clinically useful or if they meet CDC specifications. A report identifying those lots of commercial products evaluated at CDC and found satisfactory is issued monthly to 800 national and international consumer laboratories and public health organizations. During 1976, the scope of the premarket evaluation program will change as some products are eliminated and others are added. Over 4,000 different lots of reagents are to be formally evaluated in 1976.

During 1975, CDC began efforts to extend the application of the high standards of the CLIA, 1967, to more of the Nation's clinical laboratories, as directed by Congress. Small working groups of outside experts were convened, and CDC has continued to work with FDA to develop the basis for product class standards for commercial in vitro diagnostic products. Thus far, standards for identity, quality, purity, and performance have been developed for products used for the determination of glucose and hemoglobin and for the diagnosis of rubella, rabies, and syphilis. In 1976, work will continue in the major areas of clinical chemistry, microbiology, hematology, and immunology. This activity is a major collaborative effort between the two health agencies.

In addition, CDC develops and produces reference reagents for use in diagnostic laboratories for quality control purposes. During 1975, approximately 150,000 milliliters of 2,000 different reagents were distributed to State public health laboratories, CDC laboratories, other Federal agencies, U.S. Public Health Service research grantees, WHO, the Pan American Health Organization (PAHO), and to manufacturers of in vitro diagnostic products. Approximately 135,000 milliliters of reagents were added to the inventory during the same period.

Seed cultures are often needed as reference reagents for production of reagents. These efforts have increased to 343 cultures. The American Type Culture Collection has been provided with over 450 milliliter of seed virus reagents, and several lots of commercially prepared control cultures used in the quality assurance of media for growing and/or transporting N. gonorrhoeae have been evaluated.

Production of standard reference reagents for the human immunoglobulins has been a major accomplishment. Reference volumes of IgM and IgG immunoglobulin reagents have been produced, and progress has been made in the production of the IgA immunoglobulin.

During 1975, approximately 1,100 clinical laboratories were evaluated by CDC, or by the CDC-approved equivalent programs of the State of New York and the College of American Pathologists (CAP), for compliance with standards promulgated under CLIA. The standards applied included those for qualifications of personnel adequacy of internal quality control programs, and performance as demonstrated through participation in a comprehensive external proficiency testing program. Of these 1,100 laboratories, 882 were found to meet the standards for acceptance of specimens in interstate commerce. An additional 670 laboratories were exempted from the provisions of CLIA on the basis of their certification that less than 100 specimens were received annually in interstate commerce in any category.

In addition to the 882 laboratories found to meet the standards, approximately 1,770 nonlicensed laboratories participated in the CDC proficiency testing program on a voluntary basis. These laboratories are not considered to have met CLIA standards, however, because they were not evaluated on personnel qualifications or internal quality control.

To assist the SSA's Bureau of Health Insurance (BHI) and to minimize the number of examinations required of 396 laboratories which serve both as Medicare providers and as interstate laboratories, CLIA standards were applied not only to the categories of service licensed under CLIA but also to other categories of service provided for Medicare patients. Acceptance of this responsibility permitted a single on-site examination for both programs and, together with the acquisition of new laboratories conducting business in interstate commerce, resulted in an estimated 50 percent increase in the number of laboratory disciplines examined by CDC during the most recent 18-month period.

Several special proficiency testing programs were provided during 1975. Approximately 600 laboratories participating in the national gonorrhea screening program were evaluated for proficiency in isolating and identifying Neisseria gonorrhoeae, and approximately 300 laboratories were tested for proficiency in performing serologic tests for syphilis. Over 70 Indian Health Service laboratories were provided proficiency testing materials, consultation, and aid in planning further improvement.

The number of laboratories meeting the CLIA standards as administered by CDC and CDC-approved programs and approved for interstate commerce increased by 10 percent from 804 in 1974 to 882 in 1975, and the number of laboratories applying for exemption based on processing fewer than 100 specimens in each category per year increased from 454 to 670. Laboratories participating in CDC and comparable CDC-approved proficiency testing programs, including the licensed, nonlicensed, and reference laboratories, increased from 2,273 to 2,652. Quality control deficiencies among a representative sample of licensed laboratories, having decreased by 34 percent between the first and second annual evaluation, were shown to have decreased an additional 37 percent between the second and third evaluation. The previously observed upward trend of grades of licensed laboratories with proficiency testing samples continued during 1975.

Improvement was observed in the disciplines of bacteriology, parasitology, chemistry, toxicology, immunology, hematology, and immunohematology. Despite this improvement, however, the proficiency testing program provided ample evidence during 1975 of the continued existence of poor performance among a percentage of laboratories offering service to the public, both in interstate commerce and intrastate service. Experience has shown that poor performance can be corrected, but only if more effective and scientifically objective evaluation programs are provided and governmental agencies insist upon correction.

Another evidence of the program's impact during 1975 was the adoption of standards established by CDC, in part or in toto, by other evaluation programs. The CAP, whose evaluation program had previously been compared to the CDC program and judged to be equal to or more stringent than the CDC program, continued to work cooperatively with CDC for the betterment of both programs. During 1975, representatives of a number of other programs asked to review the CDC standards, either as presently written or as proposed for revision, for possible incorporation into their evaluation programs. Other organizations have asked CDC to review their current standards. These include the American Society of Cytology, the American Association of Blood Banks, the American Association of Bioanalysts, the American Industrial Hygiene Association, the National Institute on Drug Abuse, the Environmental Protection Agency, the National Cancer Institute, the American Society of Internal Medicine, the Department of the Army, several State agencies, and the SSA's Medicare program. This use by other programs of experience gained by CDC is a major objective of the model program administered by CDC. It is viewed as a major accomplishment during 1975.

Perhaps the most significant accomplishment is the drafting of revised and amplified standards, expressed as proposed regulations, for the guidance of both Medicare and interstate laboratories. These revisions are based upon the standards expressed in the current regulations for interstate laboratories and recently adopted for Medicare laboratories, but they provide more explicit definitions of the quality control measures needed to minimize the probability of erroneous laboratory reports. Checklists for use in on-site examinations have been drafted, reflecting the more explicit standards.

Based upon CDC experience over the past decade, a description of the CDC proficiency testing program was drafted during 1975 to provide State agencies and other organizations with evaluation programs detailed information on the design of a proficiency testing program, test samples, grading systems, reporting systems, etc. This will fill a critical need for the increased number of State agencies and professional organizations planning to offer proficiency testing programs.

The increase of $416,000 includes $657,000 for built-in increases such as annualization of positions new in 1975, annualization of pay raises, within grade increases, one extra day of pay, postage, utility, and FTS increases, and training requirements of OMB Circular A-48, partially offset by a program decrease of $241,000 and 40 positions resulting from the one-year funding of efforts to expand the development of product class standards in cooperation with the Food and Drug Administration.

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Health education	36	$3,027,000	36	$3,013,000	---	-$14,000

The Center for Disease Control provides leadership and coordination of a national health education program aimed at preventing disease, disability, premature death, and undesirable and unnecessary health events. The primary purpose is to develop and promulgate health education goals, objectives, and priorities in order to enhance the total effectiveness of the many separate federal programs having purposes related to health education. Serving as a focal point for Departmental health education activities, the Center ensures the coordination of major Federal health education initiatives; develops and evaluates standards, criteria, and methodologies for improved health education programs for the public; and serves as a clearinghouse on health education. Working with and through governmental agencies at State and local levels, other federal agencies, and private sector organizations, the Center encourages and assists in the implementation of effective health education programs at the State and community level, including programs designed to reduce death and disability due to smoking.

In 1976, the Center will initiate and stimulate health education programs designed to meet the specific needs of special target populations such as ethnic and linguistic minority groups, and the urban and rural poor, the elderly, and the handicapped. Evidence indicates that these target groups are not being adequately reached by current health education efforts. For example, projects with the National Medical Association and the American Lung Association will develop and introduce health education materials into the practices of health workers, including physicians serving minority groups at high risk of disease. Also, a project with the New Mexico Health Coalition will plan, conduct, and test methods for effective health education for isolated Indians and rural communities throughout the State. Work will be carried out with and through existing Department and other Federal programs such as the Cooperative Extension Service of the U. S. Department of Agriculture, Medicare, Medicaid, the Indian Health Service, and the community health services programs.

In addition, the Center will seek to develop means of evaluating the impact of health education on consumer utilization of the health care system to provide input for Departmental policy on reimbursement for health education under existing and future health insurance plans. Such activities will test the assumption that effective health education can improve the health status of individuals and enhance the potential contribution and efficiency of comprehensive health insurance programs.

In 1976, the Center will continue and strengthen major education efforts to help reduce the health consequences of smoking. In the U. S. each year, there are 25,000 deaths from lung cancer, and 1,000,000 deaths from cardiovascular disease. Cigarette smoking is a major contributing factor in the development of these conditions, yet, over one-third of the adult population continues to smoke.

A majority of anti-smoking programs have been carried out in conjunction with activities sponsored by the National Cancer Institute, NIH. Direction of anti-smoking programs in 1976 will include expansion of smoking research and will involve the National Heart and Lung Institute, National Institute on Alcohol Abuse and Alcoholism, and other agencies which have legitimate concerns in this area. As

anti-smoking activities are expanded and as knowledge about behavioral patterns of smoking is obtained, it will be applied in the development of broader health education initiatives.

School health programs in the 5th, 6th, and 7th grades, based upon but not limited to smoking education, will be operational in more than 125 school districts in 1975. In 1976, smoking and health education programs will be introduced in 50 additional school districts. Mass media approaches conducted over the past several years in the area of smoking behavior will be assessed and new approaches tried, with the objective of using smoking as a prototype for other health education programs. Successful elements of the community laboratory program conducted in San Diego, California, over the past several years will be repeated in other communities.

In 1974, work was initiated with the National Health Council to determine the feasibility and utility of a National Center for Health Education, based in the private sector, as recommended by the President's Committee on Health Education. The recommendations regarding the establishment of a National Center are expected during the fourth quarter 1975.

In 1975, the Center is identifying and cataloging health education activities of the Department and other Federal agencies as the initial step in developing a data base for the establishment of a focal point for coordinating Federal health education initiatives. The survey will define those health education programs now being carried out, identify their objectives and audiences, determine their impact in terms of the achievement of stated objectives, identify needs for future programming, and establish a data base for setting health education objectives which will assure that specific target audiences receive appropriate health education services.

Health education efforts related to smoking and health contributed to the reduction of the harmful health effects of cigarette smoking on the American people. Progress in this continuing effort is indicated by the fact that the number of adult cigarette smokers is now estimated at 51 million or 36 percent of the adult population, and that the proportion of teenage boys (12-18) smoking cigarettes has leveled off at under 16 percent, below the level of the 1950's. However, a major program concern is the alarming increase in the percentage of teenage girls who smoke (8.4 percent in 1968 compared to 15.3 percent in 1974). Another significant indicator of progress in reducing the health impact of cigarette smoking is that the average cigarette being consumed today yields approximately 19 mg. of tar and 1.3 mg. of nicotine compared with 40 mg. of tar and 2.3 mg. of nicotine 25 years ago. This reduction is directly traceable to a change in public demand based on growing concern for the health hazards of smoking. Unfortunately, the per capita consumption of cigarettes which had dropped to 3,985 in 1970 but has steadily risen to 4,250 in 1974, also has alarming program implications.

Smoking and health educational activities were coordinated with those of the many medical, civic, and educational groups which share the Government's concern with the smoking problem. Activities included participation on the National Interagency Council for Smoking and Health along with four other Government agencies and some 30 voluntary agencies. Technical assistance on anti-smoking programs was provided to universities, State and local health departments, voluntary health agencies and other groups, organizations and individuals.

A community program development activity produced specially developed health education materials which were provided to the public in some 17 communities. Another such program involving a smoking and health project on total community organization and utilizing a consumer dial-access Tel-Med system consisting of 167 English and 90 Spanish tapes, averaged 642 calls per weekday and 415 calls on Saturday from persons having smoking and health concerns. Professional organizations are helped to sensitize and effectively involve health professionals in health education activities, especially smoking prevention and control. School health curriculum projects involving some 75 school districts around the Nation completed the third and final phase of smoking and health school health curriculum training. A majority of community agencies now support the program at the 5th, 6th, and 7th grade level. A program research and evaluation effort concerned with the question of teenage up-take of smoking produced a Teenage Self-Test which provides the individual adolescent with an opportunity to gain insight into his decision to smoke or not to smoke. Surveys of smoking habits of teenage, adult, and health professional groups are supported which provide valuable research information for program evaluation.

The smoking and health issue is being kept before the public through major information programs in the news media and the press. Target groups are the woman smoker, the smoker who plans to quit, but who needs something to trigger him to action, the 18-21 age group, and the continuing smoker.

Abstracted materials from the world's literature on smoking and health are prepared for computer storage and retrieval and are used to produce a periodical abstract Bulletin on Smoking and Health, an annual bibliography, and a directory of on-going research. Distribution of the bulletin and communications regarding the directory stimulated 25 to 50 queries for technical information per week.

As required under the Public Health Cigarette Act, the annual report on the health consequences of smoking has been prepared and submitted to the Congress.

The decrease of $14,000 includes an increase of $7,000 for annualization of pay raises effective in 1974, and a decrease of $21,000 for non-recurring purchases of equipment in 1974.

Occupational Health

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	660	$10,966,000	673	$12,178,000	+13	+$1,212,000
Other expenses	---	21,020,000	---	20,003,000	---	-1,017,000
Total	660	31,986,000	673	32,181,000	+13	+195,000
Subactivities:						
Grants	---	$4,252,000	---	$1,900,000	---	-$2,352,000
Section 301 and 311 of the Public Health Service Act.						
Direct operations	660	27,734,000	673	30,281,000	+13	+2,547,000
Sections 301, 311, 327, and 328 of the Public Health Service Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.						

Grants

	1975 Estimate		1976 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
1. Non-competing continuations	60	$2,427,000	45	$1,900,000	-15	-$527,000
2. New grants	26	1,825,000	---	---	-26	-1,825,000
Total	86	4,252,000	45	1,900,000	-41	-2,352,000

Research grants are used to complement the research effort of the National Institute for Occupational Safety and Health. They provide research competencies from qualified institutions in certain fields not available within the Institute. These include research in coal workers pneumoconiosis; noise and its effect on human performance and behavior; review of the epidemiology, minerology, geology, industrial uses, and pathologic effects associated with handling asbestos; agricultural safety; occupational health in small industries; and occupational hazards

of laser material processing. It is expected that 61 research grants in the amount of $2,252,000 and 45 research grants in the amount of $1,900,000 will be awarded in 1975 and 1976 respectively.

Training grants are used to support (at educational institutions) programs and curricula development designed to prepare qualified researchers, administrators, teachers, professional, and other practitioners, in all aspects of occupational safety and health subject matter. This effort is to aid in meeting the needs/demands of government, industry, labor, academia, and other sectors of society for adequate numbers of qualified people to accomplish the purposes of the Occupational Safety and Health Act. In 1975, it is expected that 25 training grants in the amount of $2,000,000 will be awarded to continue active grant supported training programs and initiate new grants.

The decrease of $2,352,000 includes a mandatory decrease of $352,000 resulting from non-competing research grants terminating, and a program decrease of $2,000,000 resulting from the one-time funding in 1975 of the training grant program.

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Direct operations.....	660	$27,734,000	673	$30,281,000	+13	+$2,547,000

The National Institute for Occupational Safety and Health conducts research, develops criteria for occupational safety and health standards, and provides technical services to government, labor and industry, including training in the recognition, avoidance, and prevention of unsafe or unhealthful working conditions and the proper use of adequate safety and health equipment. These functions are designed to reduce the high economic and social costs of occupational illness and injury through the prevention and control of occupational diseases and hazards. They are authorized under the Occupational Safety and Health Act, Federal Coal Mine Health and Safety Act, and Public Health Service Act as amended.

The Institute's major continuing objectives and responsibilities are to conduct the research necessary to develop recommended occupational safety and health standards for submission to the Department of Labor, to set health standards for coal mine workers, to conduct industry-wide epidemiological studies, to stimulate occupational health and safety programs in State and local governments and in industry, and to provide technical assistance and training.

Currently, the most visible outputs of NIOSH are criteria documents transmitted to DOL, hazard evaluations performed, and persons training in occupational health and safety. The expected output in 1976 is 14 criteria documents to be transmitted to DOL with an output of 26 anticipated in 1977 resulting from program increases in 1975. The Institutes resources for surveillance, laboratory and field research activities will continue to support the production of criteria documents. It is anticipated that the number of hazard evaluations will increase from 110 in 1974 to around 200 in 1976. The number of persons trained on a reimbursable basis will remain approximately 1,300 per year.

The increase of $2,547,000 and 13 positions in 1976 includes $1,275,000 for mandatory increases such as annualization of new positions funded for part of year in 1975, within grade increases, annualization of the 1975 pay increase, one extra day of pay; and a program increase of $1,272,000 specifically to expand a program in occupational carcinogenesis. With the tragic vinyl chloride problem, and more recently the arsenic problem, it is imperative that the Institute vigorously attack the problem related to exposure to potential carcinogens in the workplace.

This occupational carcinogenesis will allow for the initiation of a program to support three industry-wide epidemiological studies on worker populations with unusually high cancer rates and on worker populations exposed to known animal carcinogens.

Some of the Institute's specific objectives for 1976 include:

1. Completing criteria of 14 hazardous substances or harmful physical agents including: chlorine, fluorine, cyanide, tetrachloroethylene, and hydrogen fluoride;

2. Publishing the sixth annual list of Toxic Substances;

3. Providing for an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung Benefits;

4. Stimulating occupational health and safety programs in State and local governments and in industry, and providing technical assistance and information through field stations and regional offices;

5. Responding to approximately 200 requests from employers or authorized representatives of employees for determination of whether substances normally found in place of employment have potentially toxic effects;

6. Conducting industry-wide epidemiologic studies and research related to carcinogenic and potential carcinogenic substances and the latent long-term effects on workers and their families including genetic abnormalities; and

7. Completing the final report of data from the National Occupational Health Survey.

During 1975, the Institute will:

1. Complete development of 14 criteria for occupational safety and health standards including: benzene hexavalent chromium compounds, ammonia, chloroform, oxides of nitrogen, and egress from high structures;

2. Test and certify more than 200 protective devices and samplers for use by coal miners;

3. Conduct industry-wide epidemiologic studies of the effects of chronic or low level exposure to industrial materials, processes, and stresses on the potential for illness, disease, or loss of functional capacity in past and present workers in

10 industries, including studies in the baking industries, hospital operating room personnel, workers in the aluminum reduction industry, and talc industries;

4. Respond to about 180 requests from employers or authorized representatives of employees for determination of whether substances normally found in place of employment have potentially toxic effects;

5. Develop and demonstrate prototype in-plant occupational safety and health programs: including complete testing of a system of university managed industrial clinics for the provision of occupational safety and health services to small industries;

6. Provide 1,300 man-weeks of training on a fee-for-service basis in the avoidance or elimination of unsafe and unhealthful working conditions;

7. Publish the 1975 list of Toxic Substances which has approximately 44,000 entries;

8. Receive preliminary report of data from the National Occupational Health Survey; and

9. Complete the second round of medical examinations of the 90,000 underground coal miners in order to assure detection of physical impairment due to unhealthful working environments in accordance with the Federal Coal Mine Health and Safety Act.

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Buildings and Facilities

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses	---	$3,288,000	---	---	---	-$3,288,000

(Title III of the Public Health Service Act)

The Buildings and Facilities activity provides funds, which remain available until expended, for the planning, construction, alterations, repairs, extension, and equipment of facilities of, or used by, the Center for Disease Control.

During 1975, Building 8 at the CDC headquarters building complex in Atlanta, Georgia, was completed and occupied. Routine repairs and improvements on the other buildings of the Center were completed. An architectual and engineering design contract for the new Occupational Safety and Health facility in Cincinnati has been awarded. Repairs and improvements will be made to maintain facilities at acceptable standards utilizing funds available from prior year appropriations. To meet the Center's changing responsibilities, alterations will be initiated; such as, conversion of space to provide safe laboratories for carcinogenic research and renovation of silent and sound stages, including adequate fire, safety, and sanitation features to provide more effective use of present space. Alterations to existing heating, ventilating, and air conditioning systems that are essential for proper laboratory operations will be made.

No new budget authority is requested in 1976. The unobligated balance of $3,288,000 available in 1975 will be obligated during the year, resulting in a decrease of $3,288,000 in obligations in 1976.

Program Management

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	264	$5,200,000	264	$5,428,000	---	+$228,000
Other expenses	---	3,961,000	---	5,561,000	---	+1,600,000
Total	264	9,161,000	264	10,989,000	---	+1,828,000

(Sections 301, 308, 311, 314(e), 315, 317, 318, 322(e), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act; the Lead-Based Paint Poisoning Prevention Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.)

These funds will provide the executive direction and resource management staff necessary for planning, directing and evaluating all CDC program activities in 1976. The activities of the Center, being both national and international in scope, make it imperative that high quality staff support be maintained. These funds will enable the Center to fulfill its responsibility for proper stewardship of resources and to provide assistance and coordination to the Assistant Secretary for Health.

In 1976, the Center for Disease Control will continue to provide direct fund support and competent staffing to the ten Regional Offices. These offices will provide consultation, assistance, and services to State and local health agencies with respect to grant supported programs for disease control, rodent control, and prevention of lead poisoning in children, and serve as the focal point for the review of State plans and grants for the control of occupational diseases and work injuries. Also, the cost of renting building space, budgeted by GSA in 1974 and prior years, will be funded from this activity.

The increase of $1,828,000 in 1976 includes $1,600,000 for additional building space rental costs and $228,000 for other built-in increases such as annualization of pay raises in 1974, within grade increases, and one extra day of pay.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Disease Control (Title III of the Public Health Service Act).

1975 Estimate		1976	1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
2,645	$108,349,000	Indefinite	2,571	$90,141,000

Purpose: Preventing illness and maintaining scientific surveillance of diseases.

Explanation: The purpose is accomplished through project grants and a direct operation program aimed at investigations, research, and technical assistance to detect and prevent communicable and other preventable diseases or conditions. These activities are focused directly on the national goal of improvement of health care systems through emphasis on prevention rather than control.

Accomplishments in 1975: Approximately eight million females were screened for gonorrhea. Of these, 4.5 to 5.0 percent were positive for gonorrhea. In order to monitor trends in antibotic resistance of the gonococci and to evaluate the efficacy of treatment, a national therapy monitoring network has been established in 9 treatment centers. Reported cases of primary and secondary syphilis declined and recent data suggest that the trend for infectious syphilis has stabilized. Late syphilis and congenital syphilis declined but the reported cases of congenital syphilis are still twice the number reported in the late 1950's.

The latest figures show that through the first half of 1975, there were only 22,085 cases of measles, 11,836 cases of rubella, and 5 cases of paralytic polio reported in the United States. The reported cases of rubella represents a 73 percent decline compared to the average for the past five years.

In calendar year 1973 there were 30,998 cases of reported tuberculosis. For 1974 the provisional figure is approximately 30,273 cases, a decline of 2.3 percent as compared with an average yearly decline of 6 percent for the years 1967-1973. Over 215,000 doses of skin testing antigens for TB were distributed to 200 physician-investigators. These antigens are not available commercially.

The recovery of the hepatitis A virus paves the way for the development of serologic techniques that can be used to perform epidemiologic studies of hepatitis A on a national basis. The recovery of this virus is also an early step in the development of a vaccine.

The pathogenesis of Lassa fever was elucidated in CDC's high security diagnostic facility for diseases caused by new and extremely pathogenic micro-organisms.

Only three countries in the world, India, Bangladesh, and Ethiopia, continue to have endemic smallpox, down from 29 at the beginning of the Global Eradication Program in 1967. West and Central Africa have remained free of smallpox, with the last case occurring in May 1970. The Western Hemisphere is now completely free of smallpox, with the last case occurring in Brazil in early 1971.

Sixty percent of the existing target area for rat control will reach a maintenance level during the year. By the end of 1975, it is expected that 59 communities will have developed rat control programs supported in varying degrees through 41 project grants.

Seventy-seven lead screening projects have been funded since the inception of the program in 1972. In 1975, 490,000 children were screened, which represents an increase of 32 percent over the previous year.

In 1975, the Center processed 131,000 of the most difficult reference diagnostic specimens from throughout the Nation. Approximately 1.7 million different determinations were made on these specimens.

During 1975, approximately 1,100 clinical laboratories were evaluated by CDC, or by the CDC-approved equivalent programs of the State of New York and the College of American Pathologists (CAP), for compliance with standards promulgated under CLIA. Of these 1,100 laboratories, 882 were found to meet the standards for acceptance of specimens in interstate commerce. The number of laboratories meeting the CLIA standards as administered by CDC and CDC-approved programs and approved for interstate commerce increased by 10 percent from 804 in 1974 to 882 in 1975, and the number of laboratories applying for exemption based on processing fewer than 100 specimens in each category per year increased from 454 to 670.

During 1975, 269 reports of illness were received on aircraft and vessels and were investigated. Specimens were collected for laboratory analysis, and medical consultation was provided.

Progress in the continuing effort of smoking and health is indicated by the fact that the number of adult cigarette smokers is now estimated at 51 million or 36 percent of the adult population and that the proportion of teenage boys (12-18) smoking cigarettes has leveled off at under 16 percent, below the level of the 1950's.

Objectives for 1976: Federal funding for 1976 together with increased State and local support will assure the continuation of the nationwide effort of States and localities to control the intra- and inter-state spread of gonorrhea and syphilis.

A major direction in 1976 will be to further refine gonorrhea control strategies with emphasis on the cost effectiveness of procedures and programs in interrupting the spread of disease. Special efforts will be made to strengthen the communication system for epidemiologic information vital to control the interstate transmission of disease.

During 1976, immunization grants will be awarded to official health agencies which serve all areas of the Nation. These grants will continue to assist recipients in developing and refining their capabilities in carrying out comprehensive immunization programs.

Project grants will be awarded to urban areas to reduce rat infestations and to insure the maintenance of rat control programs by local governments and through voluntary community action. An additional 10 percent of the existing target area should reach a control maintenance level during 1976.

During 1976, it is estimated that 300,000 children will be tested in 35-40 project communities for lead-based paint poisoning. Appropriate hazard abatement activities will be undertaken in a minimum of 70 percent of the dwelling units where lead-based paint has been identified as the source of a child's lead exposure.

In 1976, as the new maximum security facilities at the Center become operable, research and diagnostic services will be extended. Highly specific inactivated antigens will be prepared for Marburg and Herpes B viruses as well as Lassa, and will be distributed as required.

The original target of worldwide eradication of smallpox by 1976 still appears realistic. The successful culmination of the Smallpox Eradication Program will be the first time in recorded history that man has succeeded in eradicating any disease.

An estimated 1,500 disease outbreak investigations will be conducted during 1976. Also, 8 additional locations for Epidemic Intelligence Service field assignments are planned for 1976, so that the CDC will have direct liaison with 35 State and 7 metropolitan areas through EIS officers stationed there.

Projected work in 1976 for noninfectious diseases will involve continuation of studies related to vinyl chloride and to lead. Programs in the area of clinical immunology also will be emphasized in 1976.

In 1976, the Center will initiate and stimulate health education programs designed to meet the specific needs of special target populations such as ethnic and linguistic minority groups, and the urban and rural poor, the elderly, and the handicapped. A major objective of the Center in 1976 will be to stimulate and help support health education projects designed specifically for these groups.

In 1976, smoking and health education programs will be introduced in 50 additional school districts. Mass media approaches conducted over the past several years in the area of smoking behavior will be assessed and new approaches tried, with the objective of using smoking as a prototype for other health education programs.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Occupational Health (PHS Act as amended, Federal Coal Mine Health and Safety Act of 1969, and Occupational Safety and Health Act of 1970).

1975 Estimate		1976	1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
660	$31,986,000	Indefinite	673	$32,181,000

Purpose: This program is designed to reduce occupational illness and injury through the prevention and control of occupational hazards and diseases.

Explanation: Grants and direct operation funds are used to support research, training and technical assistance programs aimed at helping government and industry to administer occupational health programs, and to develop criteria for standards necessary for the successful implementation of a safe and healthful work place.

Accomplishments in 1975: Under the Federal Coal Mine Health and Safety Act for health standards for surface coal miners, it is anticipated that the Institute will be testing and certifying more than 200 protective devices and air samplers.

In 1975, the Institute will complete development of 14 criteria for occupational safety and health standards including: benzene, hexavalent chromium compounds, ammonia, chloroform oxides of nitrogen, and egress from high structures. In addition, the documentation process will be initiated to complete 26 criteria documents in 1977.

Also in 1975, the Institute will (1) respond to about 180 requests from employers or authorized representatives of employees for determination of whether substances normally found in place of employment have potentially toxic effect; (2) publish a list of "Toxic Substances"; (3) develop and demonstrate prototype in-plant occupational safety and health programs; (4) provide 1,300 man-weeks of training on a fee-for-service basis; and (5) complete the second round of medical examinations of the 90,000 underground miners.

Objectives for 1976: The Institute's primary objectives for 1976 are to (1) complete criteria of 14 hazardous substances or harmful physical agents including: chlorine, fluorine, cyanide, tetrachloroethylene, and hydrogen fluoride, and the documentation process for 26 criteria documents will be initiated for completion in 1978; (2) publish the sixth annual list of "Toxic Substances"; (3) provide for an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung Benefits; (4) conduct industry-wide epidemiologic studies and research related to carcinogenic substances; and (5) stimulate occupational health and safety programs in State and local governments and in industry.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Buildings and facilities (Title III of the Public Health Service Act).

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$3,288,000	Indefinite	---	---

Purpose: Construction, alteration, and repair of buildings and facilities, including preparation of plans and specifications.

Explanation: Funds remain available until expended. No new budget authority is requested.

Accomplishments in 1975: Building 8 at the CDC Headquarters building complex in Atlanta, Georgia was completed and occupied. Routine repairs and improvements on the other buildings of the Center were completed. An architectual and engineering design contract for the new Occupational Safety and Health facility in Cincinnati has been awarded. Repairs and improvements will maintain facilities at acceptable standards. Space will be converted to provide safe carcinogenic research and silent and sound stages will be renovated to provide more efficient use of present space. This renovation will include provision of sanitation features. Heating, ventilating and air conditioning systems will be altered for proper and safe laboratory operations.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Program Management (Title III of Public Health Service Act).

1975 Estimate			1976 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
264	$9,161,000	Indefinite	264	$10,989,000

Purpose: This activity provides top management, staff services, and regional offices staff to assure the desired direction and development of the Preventive Health Services programs' goals and objectives. Rental payments for building space occupied by the Center are also provided by this activity.

Explanation: Executive direction of the various programs is strengthened by sophisticated planning and analysis in terms of mission accomplishment and managerial effectiveness. The regional offices assist and serve State and local health agencies and community groups in activities at the local level which are a part of national coordinated preventive health programs.

Accomplishments in 1975: The necessary staff was provided to assure policy and program leadership and to monitor and evaluate progress in achieving ongoing program objectives. The Center's increased responsibilities relating to decentralized agency accounting, negotiated contracts cost advisory services, and the DHEW personnel system were met. Payments for the Center's occupied building space were made under the newly developed Standard Level User's Charge system.

Objectives for 1976: Effective and efficient program direction, staff services, and regional office support for Preventive Health Services programs will be provided. Increased rental payments for additional building space in Cincinnati, Ohio to be occupied by the Center's National Institute for Occupational Safety and Health will be provided.

New Positions Requested

	1976		
	Grade	Number	Annual Salary
Occupational health			
Direct operations			
Epidemiologist	GS-15	1	$29,818
Scientist	GS-14	1	25,581
Industrial Hygienist	GS-14	1	25,581
Medical Officer	GS-14	1	25,581
Health Physicist	GS-14	1	25,581
Biological Scientist	GS-13	1	21,816
Medical Officer	GS-13	1	21,816
Safety Engineer	GS-13	1	21,816
Chemist	GS-12	1	18,463
Secretary	GS-5	1	8,500
Clerk-Typist	GS-3	1	6,764
		11	231,317
Commissioned Officers			
Full grade			
Biochemist		1	10,825
Senior assistant grade			
Chemist		1	10,058
Total new positions, all activities		13	252,200

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CENTER FOR DISEASE CONTROL

Preventive Health Services

Amounts Available for Obligation 1/

	1976	Interim Period
Appropriation	$133,311,000	$33,328,000
Total, obligations	133,311,000	33,328,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1976 - $10,000,000; Interim - $2,500,000.

Obligations by Activity

Page Ref.		1976 Estimate Pos.	1976 Estimate Amount	Interim Period Pos.	Interim Period Amount
	Disease control				
172	(a) Project grants	563	$33,710,000	563	$6,500,000
172	(b) Disease investigations, surveillance and control .	1,503	43,429,000	1,503	12,380,000
172	(c) Laboratory improvement	469	9,989,000	469	2,850,000
172	(d) Health education	36	3,013,000	36	753,000
	Occupational health:				
172	(a) Grants	---	1,900,000	---	475,000
172	(b) Direct operations	673	30,281,000	673	7,570,000
172	Program management	264	10,989,000	264	2,800,000
	Total obligations	3,508	133,311,000	3,508	33,328,000

Obligations by Object

	FY 1976 Estimate	Interim Period
Total number of permanent positions	3,508	3,508
Full-time equivalent of all other positions .	200	200
Average number of all employees	3,427	3,427
Personnel compensation:		
Permanent positions	$55,546,000	$14,113,000
Positions other than permanent	1,803,000	450,000
Other personnel compensation	1,272,000	318,000
Subtotal, personnel compensation	58,621,000	14,881,000
Personnel benefits	8,019,000	3,484,000
Travel and transportation of persons	3,097,000	923,000
Transportation of things	738,000	184,000
Rent, communications and utilities	8,226,000	2,056,000
Printing and reproduction	966,000	242,000
Other services	6,284,000	1,571,000
Project contracts	13,456,000	3,364,000
Supplies and materials	3,577,000	894,000
Equipment	2,118,000	530,000
Grants, subsidies and contributions	28,211,000	5,199,000
Subtotal	133,313,000	33,328,000
Less quarters and subsistence direct	-2,000	---
Total obligations by object	133,311,000	33,328,000

Justification

Disease control - Project grants $6,500,000

An estimate of $6,500,000 is requested for the period July 1, 1976 - September 30, 1976. This amount includes $5,000,000 for venereal diseases, $1,450,000 for immunization, and $50,000 for lead-based paint poisoning prevention. These amounts are required for partial year support of grants requiring continuations during this period. No rat control grants require continuation funding during this period.

Disease control - Disease investigations, surveillance and control . $12,380,000

An estimate of $12,380,000 is requested for the period July 1, 1976 - September 30, 1976. This amount was computed on the basis of 25 percent of the 1976 President's Budget request plus mandatory cost increases such as commissioned officers bonus pay, travel associated with commissioned officers entering on duty or separating, and Youth Opportunity Corps compensation and related costs.

Disease control - Laboratory improvement $2,850,000

An estimate of $2,850,000 is requested for the period July 1, 1976 - September 30, 1976. This amount was computed on the basis of 25 percent of the 1976 President's Budget requested plus mandatory cost increases such as commissioned officers bonus pay, travel associated with commissioned officers entering on duty or separating, and Youth Opportunity Corps compensation and related costs.

Disease control - Health education $753,000

An estimate of $753,000 is requested for the period July 1, 1976 - September 30, 1976. This amount was computed on the basis of 25 percent of the 1976 President's Budget request.

Occupational health - Grants $475,000

An estimate of $475,000 is requested for the period July 1, 1976 - September 30, 1976. This amount was computed on the basis of 25 percent of the 1976 President's Budget request.

Occupational health - Direct operations $7,570,000

An estimate of $7,570,000 is requested for the period July 1, 1976 - September 30, 1976. This amount was computed on the basis of 25 percent of the 1976 President's Budget request.

Program management $2,800,000

An estimate of $2,800,000 is requested for the period July 1, 1976 - September 30, 1976. This amount was computed on the basis of 25 percent of the 1976 President's Budget request.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

WITNESSES

DR. THEODORE COOPER, ACTING ASSISTANT SECRETARY FOR HEALTH
JOHN C. DROKE, DIRECTOR, OFFICE OF ADMINISTRATIVE MANAGEMENT, PUBLIC HEALTH SERVICE
PETER J. BERSANO, DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT, OFFICE OF RESOURCE MANAGEMENT, OFFICE OF ADMINISTRATIVE MANAGEMENT, PUBLIC HEALTH SERVICE
WILFORD FORBUSH, DEPUTY ASSISTANT SECRETARY, BUDGET
FAYE G. ABDELLAH, DIRECTOR, OFFICE OF NURSING HOME AFFAIRS, PUBLIC HEALTH SERVICE
DAVID N. WEINMAN, DEPUTY DIRECTOR, OFFICE OF PROFESSIONAL STANDARDS REVIEW, PUBLIC HEALTH SERVICE

Mr. FLOOD. The committee will come to order.

We have the Assistant Secretary for Health of the Department of Health, Education, and Welfare.

We already have Dr. Cooper's biography in the record but we will insert those of his colleagues not yet in the record.

BIOGRAPHICAL SKETCH

Name: David N. Weinman.

Postition: Deputy Director, Office of Professional Standards Review.

Birthplace and date: Abington, Pa., February 9, 1934.

Education: Springhouse School, Springhouse, Pa. 1945–46; Wm. Penn Charter School, Philadelphia, Pa., 1946–51 Diploma; Amherst College, Amherst, Mass. 1951–55, B.A.; Stanford Law School, Stanford, Calif. October 1958 to January 1959; Univ. of Michigan, Ann Arbor, Mich. February 1959 to February 1962, M.A. and LL.B.; Johns Hopkins School of Advanced International Studies, Washington, D.C., October 1964 to June 1971 Ph. D. Candidate.

Experience: 1973 to present: Office of Professional Standards Review, DHEW; 1971–73: OMB; 1967–71: OEO; 1969–70: Congressional Fellowship Office; 1966–67: Peace Corps, Ankara, Turkey; 1965: George Washington University—Instructor; 1962–64: Peace Corps; 1960–61: Naval Reserve Training Center; 1955–58: U.S. Navy.

BIOGRAPHICAL SKETCH

Name: Faye G. Abdellah, Ed. D., LL.D., R.N.

Position: Assistant Surgeon General, Chief Nurse Officer, PHS and Director, Office of Nursing Home Affairs, PHS.

Birthplace: New York City.

Education: Diploma, R.N. Fitkin Memorial Hospital School of Nursing (now Ann May School of Nursing) Neptune, N.J., 1942; Rutgers University, Douglass College, New Brunswick, N.J., (liberal arts, chemistry), 1942–44; bachelor of science (B.S.) Teachers College, Columbia University, New York, N.Y., 1945; master of arts (M.A.) Teachers College, Columbia University, New York, N.Y., 1947; doctor of education (Ed. D.) Teachers College, Columbia University, New York, N.Y., (education and psychology), 1955.

Experience: present: Assistant Surgeon General, Chief Nurse Officer, PHS and Director, Office of Nursing Home Affairs, PHS.

1949 to present: Member of Commissioned Corps U.S. Public Health Service with current rank of assistant surgeon general (Navy rear admiral).

ACADEMIC HONORS AND PROFESSIONAL AWARDS (17 HONORS RECEIVED)

1. 1942, magna cum laude school of nursing graduate.
2. 1942, 4 year scholarship to Rutgers University, New Jersey.
3. 1955, Pi Lambda Theta, National Honor and Professional Association in Education.
4. 1963, recipient, Army Nurse Corps Award—honored for contributions to nursing education and nursing research.
5. 1964, recipient, Federal Nursing Service Award of the Association of Military Surgeons of the United States for outstanding accomplishment in advancing professional nursing.
6. 1967, doctor of laws (LL.D.) Honoris Causa, Case Western Reserve University, Cleveland, Ohio for being a pioneer in nursing research and responsible for the advent of the nurse-scientist scholar.
7. 1968, Sigma Theta Tau, National Honor Society of Nursing.
8. 1969, recipient, Nursing Education Alumni Association, Teachers College, Columbia University, "Award for Distinguished Achievement in Research and Scholarship."
9. 1970, recipient, Ohio State University Centennial Award for Achievements in Nursing Research, Columbus, Ohio.
10. 1970, presented the Nickolai Ivanovich Pirogov Medal by Dr. V. Timakov, president, the Academy of Sciences, U.S.S.R. for furthering scientific contributions for the benefit of all mankind.
11. 1971, recipient, Helen J. Evans Award from the Alumni Association of the Ann May School of Nursing for contributions to nursing and research, Neptune, N.J.
12. 1971, recipient, Meritorious Service Honor Award by the U.S. Department of Health, Education, and Welfare for exemplary service and for developing outstanding training programs for professional and ancillary health services personnel with the National Center for Health Services Research and Development.
13. 1973, designated as one of the Nation's well-qualified 36 charter fellows of the Academy of Nursing by the American Nurses' Association board of directors.
14. 1973, recipient, Distinguished Service Honor Award for exceptional leadership, total professional commitment, and distinguished performance and contributions to national and international health services and nursing research and nursing education.
15. 1973, doctor of laws (LL.D) Honoris Causa Ad Gradum, Rutgers University, The State University of New Jersey, New Brunswick for being a distinguished leader of the nursing profession and instrumental in improving nursing education and research.
16. 1974, recipient, the Teachers College, Columbia University Medal for Distinguished Service in recognition of outstanding contributions to the profession of nursing and service to mankind.

She is the author or co-author of more than 78 publications in nursing and related health fields. Some of her books have been published in numerous languages: Patient Centered Approaches to Nursing, (Macmillan 1969) 1969 Effect of Nurse Staffing on Satisfactions with Nursing Care (American Hospital Association, 1958); Intensive Care—Concepts and Practices for Nurse Specialists (Charles Press, 1969), and New Directions in Patient-Centered Nursing: Guidelines for Systems of Service, Education, and Research, (Macmillan, 1973).

Opening Statement

Dr. Cooper. Mr. Chairman and members of the committee, I am pleased to appear today in connection with the 1976 budget request for activities of the Office of the Assistant Secretary for Health. As you know, this Office is the focus of leadership for the Public Health Service, and as such it provides the management and administrative services, the policy development, and the overall coordination necessary for the effective functioning of the Department's principal health agencies. In addition, the Office provides policy guidance to the Social Security Administration and the Social Rehabilitation Service with respect to

their administration of medicare and medicaid. It is also responsible for certain specific program activities, such as international health and national physical fitness and sports program.

I should like to spend a few minutes reviewing the strategy that we are using as the basis for critical program and budget decisions in the Public Health Service. This strategy is outlined in our forward plan for health. The forward plan is a means of orienting our planning according to national health issues and problems. This approach will allow us to plan our programs in such a manner as to achieve the best mix of our resources to address our major national health issues.

The foward plan represents, we believe, a significant step in the development of a publicly responsive planning process. It is not a static document, but will be constantly updated to keep up with evolving health care problems and issues. The five major themes of the forward plan are: Prevention, preparing for national health insurance, quality assurance, tracking health status and the health industry, and knowledge development.

The first of these, prevention, is directed towards those programs which prevent premature death, illness, injury, and serious mental health problems.

It seems fairly certain that before 1980 we will have some form of National Insurance and the second theme in our forward plan addresses this expected development. There is substantial evidence that our current health care system is not well prepared to accommodate the increased demands that will result from the adoption of a comprehensive health insurance plan. We must now begin to initiate actions which will bring about changes in the health care system to assure access of all members of our society to health care at a reasonable cost.

NATIONAL HEALTH INSURANCE

Mr. FLOOD. How many nations in the world have national health insurance now?

Do you know off hand?

Dr. COOPER. Offhand, I don't know.

Mr. FLOOD. Can you name any of them?

Dr. COOPER. I can name several: Great Britain, Sweden, Denmark, Italy, West Germany, France all have national health plans. I think all the European countries by and large have some form of nationalized plan. However, they are not the same in their coverage on operations.

Mr. FLOOD. How about the so-called young nations?

Dr. COOPER. Many of the young nations developing health care programs——

Mr. FLOOD. I am speaking of national health insurance.

Dr. COOPER. I was going to make the distinction. Several of the evolving nations are not at that state of development to assure access to health care.

Mr. FLOOD. In Italy they have national health insurance but they do not have the second step. They just have the mere insurance. You are talking about more than that.

Dr. COOPER. Yes, I am saying that different countries have approached the problem of assuring access to their citizens by different mechanisms. Part of this is a reflection of their capabilities.

Mr. FLOOD. For the record, will you give us a list of the nations that have, as of today, national health insurance and then secondly the nations that have not only national health insurance, but also the liberal services connected with it. So give us the ones who have only national health insurance as such and secondly the ones that have national health insurance and also the service from it.

Dr. COOPER. Fine, we shall provide the listings.

COUNTRIES HAVING NATIONAL HEALTH INSURANCE [1]

Services for segments of population (e.g. workers, aged) or partial services generally available

Afghanistan
Algeria
Argentina
Barbados
Bolivia
Brazil
Burma
Taiwan (China)
Colombia
Costa Rica
Dominican Republic
Ecuador
Egypt
El Salvador
Ghana
Greece
Guatemala
Guinea
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Italy
Ivory Coast
Jordan
Kenya
South Korea
Lebanon
Libya
Malta
Mexico
Morocco
Nicaragua
Nigeria
Pakistan
Panama
Paraguay
Peru
Philippines
Portugal
Senegal
Singapore
Spain
Sri Lanka
Tanzania
Trinidad & Tobago
Tunisia
Turkey
Upper Volta
Uruguay
Venezuela

Services essentially complete for whole population

Australia
Austria
Belgium
Canada
Chile
China (PRC) [2]
Cuba [2]
Cyprus
East European bloc: [2]
  Albania
  Bulgaria
  Czechoslovakia
  Hungary
  Poland
  Romania
  Yugoslavia
Federal Republic of Germany
Finland
France
German Democratic Republic [2]
Iceland
Ireland
Israel
Jamaica [2]
Japan
Kuwait [2]
Luxembourg
Malaysia [2]
Netherlands
New Zealand
Norway
Sweden
Switzerland
USSR [2]
United Kingdom

[1] Source: Department of Health, Education, and Welfare, Social Security Administration Publication 74–11801.
[2] Services provided by national government.

Dr. COOPER. Quality assurance, the third theme, is closely related to all the others. We must not only make health services available to the people, but we must also put in place a system which assures the continued delivery of high quality care.

The fourth theme, tracking health status and the health industry, has as its objective the collection and coordination of reliable baseline health statistics. Health policy planners and administrators at all levels of government and in the health industry must have the basic data they need to plan and direct their health programs.

Knowledge development relates to the support and development of biomedical and behavioral research which is essential to the understanding of the causes, prevention, diagnosis, and treatment of the diseases of man. It also includes research designed to develop better methods of organizing, delivering, and health research, and health services.

Basically, that is our forward plan for health. The plan was developed with the assumption that our pluralistic health care system is worth preserving—that it can correct its deficiencies, respond to rising demand and function successfully and efficiently, for the benefit of all our people. It exemplifies the leadership which my office, in cooperation with the agencies in the Public Health Service, can exert. In addition, my staff and I meet biweekly with the Public Health Service agency heads as a health policy board to develop health strategy, resolve problems, and coordinate our management efforts.

Mr. PATTEN. Doctor, you are talking about the people in your administration, when you say the Public Health officials. That would not include the president of the Memorial Hospital in New York?

Dr. COOPER. No. I mean the six agencies of the Public Health Service which are within our jurisdiction.

Let me turn to a few specifics about the budget request that is before you.

REGIONAL MANAGEMENT

In 1976, $6.7 million are requested to support the Public Health Service's regional management functions. The Regional Health Administrators, who are responsible to me, are the principal Public Health Service officials in 10 Regional Offices of the Department. Their staff provides advisory, administrative, and managerial support of health programs administered in the regions and coordination of health services with State and local health agencies. Also, funded through the activity is the headquarter's staff which provides advice to my office in matters pertaining to coordination and management of operations in the 10 regional offices.

The Public Health Service's regional staffs have an impact on approximately 6,000 grants totaling $1.46 billion and involving 44 health programs. The combined effort of the regional and headquarters staff assures uniform and equitable implementation of health policies, programs, and operational guidelines at the regional level.

In fiscal year 1975, a major new management program—the regional health administrators work program—was implemented to provide a structured process for relating allocation of regional resources to regional program priorities within the contours of national health priorities.

PROGRAM DIRECTION AND SUPPORT SERVICES

The program direction and support services activity for which we are requesting $13.7 million, provides the staff support to the Assistant Secretary for Health in carrying out his managerial responsibilities. As you know, I serve as the line manager of the six health agencies and as staff advisor to the Secretary on health matters. Some of our current efforts to improve the management of the Public Health Service include the development of an updated set of grant management policies and a system to improve the issuance of regulations.

Other significant accomplishments have included an implementation planning system for analysis and assessment of new health legislation so as to insure more effective program implementation. In the international arena, we have aimed at complementing the domestic mission of the Department by strengthening the bilateral health programs between the Department and ministries of health of several countries, including the U.S.S.R., Poland, Mexico, Japan, and Romania. We have also strentghened our liaison with other Federal departments and agencies that have major responsibilities in the health care fields.

Mr. FLOOD. That is a mixed bag.

Dr. COOPER. Yes, sir. There is a large amount of liaison work that needs to be accomplished between agencies like the Department of Defense.

Mr. FLOOD. I mean the agencies involved.

That is quite a mix.

Dr. COOPER. Yes, sir.

That is a sampling. We have something in the order of 450 activities in that large mix. We have the tripartite agreement with Canada and activities with the United Kingdom and activities I have not mentioned.

It is a wide mix of programs.

HEALTH CARE ASSURANCE

We are requesting $2.3 million for the support of the health care assurance activities.

This goal of assuring the highest quality of health care consistent with the best available knowledge is an essential interlocking element in our Federal health strategy. We must be certain that improvements in the quality of care are carefully implemented so as not to reduce the availability to the consumer of health and health-related services.

Under the direction of the Deputy Assistant Secretary for Quality Assurance, three offices coordinate the overall Department effort to assure quality standards for health care. The Office of Professional Standards Review coordinates the departmental efforts on professional standards review organizations programs. Presently there is PSRO activity in all but 6 States, including 91 planning PSRO's, 14 conditional PSRO's, and 13 support centers. By the end of this fiscal year, we hope to convert 40 to 50 of the planning PSRO's to conditional status and to add 20 new planning PSRO's. The Office of Population Affairs coordinates and is responsible for all departmental programs relating to population research and family planning. Family planning services will be available through organized programs supported by the Department to approximately 3.5 million

low-income women, and through services of private physicians reimbursed by these programs, an additional 1.5 million women will be served. Thus, we will meet our goal of serving 5 million women.

Mr. FLOOD. You are not talking about abortion. You are talking about family planning as distinguished from abortion as such?

Dr. COOPER. Yes, sir. That is correct, we are not talking about abortions.

The Office of Nursing Home Affairs provides a focal point for coordinating the Department's activities in this highly sensitive and critical area. As I previously reported to you, this office recently undertook a survey of 295 nursing homes throughout the country.

Mr. FLOOD. How many are there in the country, do you know?

Dr. COOPER. About 16,000 participating in medicare, title XVIII, and medicaid, title XIX programs.

PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

The Assistant Secretary for Health has been given responsibility for providing leadership to the President's Council on Physical Fitness and Sports and we are requesting $578,000 for its support. This Council was formerly funded under the Human Development appropriation and is responsible for a national program of physical fitness and sports to promote private support for physical fitness and mass amateur sports development programs.

SUMMARY

In summary, the budget request for this appropriation is $23,288,000. It does not reflect any increase in manpower for the Office of the Assistant Secretary for Health. The total increase of $1,263,000 over 1975 is to provide for mandatory costs.

Mr. Chairman, I will be pleased to answer any questions you may have.

NUMBERS AND TYPE OF NURSING HOMES

Mr. FLOOD. That 16,000 figure you gave me in answer to questions on nursing homes, are you talking about private nursing homes as distinguished from public facilities?

Dr. COOPER. That includes all of them in several different categories.

Mr. FLOOD. List the categories.

We are concerned and have an interest in various ways as between private nursing homes, public, some which involve State funds and supervision, et cetera, as distinguished from so-called private nursing homes. When you get time can you break those down for us?

Dr. COOPER. Dr. Faye Abdellah is with us. She will give you a breakdown.

Mr. FLOOD. I asked a question about how many nursing homes we had all together. I wanted to know how many were public and how many were private.

Dr. COOPER. Dr. Abdellah provided the following information: There are 16,000 participating in medicare and medicaid programs. Ninety-five percent of them are profitmaking. Five percent are not-profitmaking, including county and State institutions.

Mr. FLOOD. You will repeat that, 95 are profitmaking?

Dr. COOPER. Yes, sir, and 5 percent are nonprofit. That includes county and State institutions and a very small number that are independent, nonprofit institutions.

It is interesting that 50 percent of the patients are in that 5 percent group.

Of the 16,000, 9,900 are intermediary care facilities and 7,000 are what are termed skilled nursing facilities, where a special higher level of care is provided. In addition to the 16,000 that participate within the Federal programs, there are an additional 7,000 that are noncertified by States and therefore are not eligible for medicaid under title XVIII, medicaid under title XIX. These are private-home, two-and three-bed operations.

Mr. FLOOD. But they are operations.

Dr. COOPER. They have patients in them; yes.

Mr. FLOOD. Are they subject to inspection by local or State authorities of various types?

Mr. COOPER. Many are licensed by the local jurisdiction.

Mr. FLOOD. County or municipality?

Dr. COOPER. Yes; both may grant a license.

Mr. FLOOD. That is distinguished from a State license.

Dr. ABDELLAH. They can have a city or county license, but are not State certified. Medicare and medicaid programs, only State-certified facilities are eligible to participate.

Mr. FLOOD. But you can have a local or county or municipal place certified and they are not certified by the State.

Dr. ABDELLAH. Yes, sir. They are small residential boarding type homes.

Mr. FLOOD. The only inspection would be located by local auspices.

Dr. ABDELLAH. Yes, sir.

Many of these homes have fire hazards and provide poor quality care.

HEALTH CARE SYSTEM

Mr. FLOOD. In your opening statement you said, "We must now plan to initiate actions that will bring about changes in the health care system to assure access of all members of our society to health care at reasonable costs." What actions are you going to undertake in the coming year to achieve access to health care at a reasonable cost? That is quite a sentence.

Dr. COOPER. Yes, sir.

The mandate there was derived from the first congressional finding in the National Health Planning and Resource Development Act of 1974. Among the things that we are doing to achieve this objective, the National Health Service Corps is an example of one of the more successful ones that is operating, and in which we have a great deal of interest. In that program we are identifying communities and areas that have not had sufficient medical care resources. The people living there did not have access to proper care, and we are providing them with health services and facilities to get this care.

That is one method of dealing with some of the important deficiencies and capacity that we have.

Mr. FLOOD. Providing facilities do get there? Do you mean buses and transport?

Dr. COOPER. No, sir, I mean development of clinics.

HEALTH QUALITY ASSURANCE

Mr. FLOOD. Now you are asking for $2.3 million and 87 jobs for the health care assurance activities. How does this organization, as an organizational unit relate to this Bureau of Quality Assurance that we are talking about located over in the Health Services Administration that you just mentioned and they have already asked us for an appropriation of $54,600,000 and 340 jobs.

Dr. COOPER. Let me try to explain the relationship of those two programs.

Mr. FLOOD. That would be a good idea.

Dr. COOPER. The quality assurance activities of the Department are delegated to the Office of the Assistant Secretary for Health.

Now this requires coordination and supervision of activities not only in the Bureau of Quality Assurance of HSA, which is one aspect of the program, but also activities in SSA, the Bureau of Health Insurance in Social Security and activities in the Social and Rehabilitation Services. So the total program is more than just the activity that is executed by the Bureau of Quality Assurance. It involves three different agencies to working together.

Mr. FLOOD. It is a good thing I asked you the question.

Dr. COOPER. Yes, sir. I think it is important to make that distinction because it has created some difficulty in the past by thinking we were having excessive layering.

Mr. FLOOD. It gave me some difficulty 5 minutes ago.

Dr. COOPER. Yes, sir.

I think this is a distinction of important different activities in different agencies required to make that programing.

PROFESSIONAL STANDARDS REVIEW

Mr. FLOOD. How many of those 87 jobs are assigned to the Office of PSRO?

Dr. COOPER. Thirty-six of the eighty-seven positions are assigned to the Office of Professional Standards Review.

Mr. FLOOD. How does the work in that group differ from the work being done by the 173 people budgeted in the PSRO program that is part of the Health Services Administration appropriation?

Dr. COOPER. The actual way the program is executed is by supporting the development of the units out in the 203 regions in the country. The actual supervision, awarding of contracts, review of operations, setting guidelines for those operations are done by the Bureau of Quality Assurance of the Health Services Administration.

Mr. FLOOD. How does the 173 differ from the PSRO staff?

Dr. COOPER. The Office of Professional Standards Review staff in the Office of the Assistant Secretary is responsible for the development of policy; for the planning functions; for the coordination of relationships with the Bureau of Health Insurance in the Social Security Administration, the Social and Rehabilitation Service, the Medical Services Administration, and the Bureau of Quality Assurance on Professional Standards Review Organizations matters; and devising the various ways that utilization review will be integrated into those other functions. In other words, the policy development and evaluation are done by the staff up in the OPSR and not in BQA.

UTILIZATION REVIEW REGULATIONS

Mr. FLOOD. You talk about implementation. What is the status of the implementation of the utilization review organization? What I mean is, a number of small hospitals write to us every day. They are urging relief. They want relief from this confounded utilization review regulation.

They want to get out from under that. What is the burden of these regulations impose on these small hospitals and what are you doing about it?

The big deal now is the small hospital. Let's do away with the Tajmahals. That is all right. But now these small hospitals are screaming bloody murder.

Dr. COOPER. We know it has not been well-received, particularly where there are small units in a rural setting. We know they have found difficulty achieving the type of review asked for in the regulations.

As you know, the Secretary has extended the time for implementation of that program to July 1 in response to these concerns in order to allow the individual institutions in these settings to provide alternative proposals which would be acceptable to their States and would achieve the real objectives of utilization review set forth in the regulations.

You know utilization review had been going on before. The new dimension added was to certify, as soon as possible, the necessity of the hospital admission. It was in these situations that the small hospitals with very few physicians had difficulty in trying to meet the regulations.

In some cases it requires a review staff that need not include only doctors. Review can be performed by other health professionals, but negative decisions can only be made by doctors. Some States had already had experience with this type of review in the rural setting, like Utah. Other States which had not tackled this situation before did not have time to provide alternate proposals such as this. We are sensitive to the need to have some practical methods so that the doctors involved in this utilization review can accomplish it within a practical setting.

Mr. FLOOD. We will remind you of that statement.

Dr. COOPER. Yes, sir.

TRAINING OF NURSING HOME PROFESSIONALS

Mr. FLOOD. In your justifications you say in 1976 efforts will continue to improve nursing home care and facilities through intensive training now of the nursing home inspectors and through development of a method of grading nursing homes.

Of course, we are very happy to see that you are continuing your efforts in that area. That is fine. But let me ask you, what happens here—an inspector goes out and finds a series of deficiencies in one of these nursing homes. What do we do, close it up, cut off the funds, or provide that nursing home with resources to improve the situation? What about it?

Dr. COOPER. I'm sure we are sensitive to the implication of arbitrary or less arbitrary closing of beds when people need them in these facilities. So that in these surveys and inspections when deficiencies are identified, opportunity is given for rectification of the deficiency.

If the institution does not respond within an appropriate framework of time to correct the deficiency, then the facility has its Federal support withdrawn.

Mr. FLOOD. How many people are going to receive training under the nursing home program?

Dr. ABDELLAH. We have trained 2,000 State surveyors. We need an additional 2,000 in terms of the needs to survey the intermediate care facilities. There have been approximately 78,000 health professionals trained in long-term care. This is essentially short-term training.

Mr. FLOOD. Of the number you will train in 1976, how many will be health service providers who are not actually working in homes?

Dr. ABDELLAH. We have estimated that we would need to train 15,000 health service providers each year through short-term continuing education programs to meet the needs. We have trained over 78,000 over a 4-year period. We hope 5,000 or 6,000 might participate in short-term training.

Mr. FLOOD. Specifically you are talking about programs. What kind of training programs do you actually conduct for the nursing home personnel?

Dr. ABDELLAH. We provide short-term training under the 1971 Nursing Home Improvement Initiative program.

These are to be short-term courses 3 to 6 weeks in length.

Mr. FLOOD. What kind of training programs are there for the people on the job now?

Dr. ADBELLAH. These are essentially management courses. There are also programs for nutritionists. There are programs for nursing aides to train them in administering medications. There are programs for physical therapists and programs for the other various health disciplines.

For the nurses emphasis is placed on the management of a nursing home. In addition, we have started an experimental training program in the eight States in region IV to train providers and health personnel in the use of patient assessment tools.

Mr. FLOOD. Do you encourage the R.N.'s to moonlight for an additional degree?

Dr. ABDELLAH. Yes, we do. Unfortunately, unlike the hospitals, most nursing homes do not have benefits nor provide opportunities for continuing education. This is one of the things we are quite concerned about because it contributes to a high turnover.

Mr. FLOOD. I would think so.

Have you been in touch with anybody about having the R.N.'s have opportunities like that so they can moonlight in a nearby school that gives a B.S. in nursing?

Dr. ABDELLAH. Yes, sir, we have encouraged this by working with the American Nurses Association, the National League for Nursing, and the nursing home associations.

Mr. FLOOD. It is a big deal now.

Dr. ABDELLAH. Yes, sir. It is a very good opportunity for them.

REGIONAL OFFICE CENTRAL STAFF

Mr. FLOOD. Doctor, you are asking for $6.7 million and 230 jobs for support of the regional office operations. How many of these 230 positions are going to be in Washington, D.C.?

Dr. COOPER. Twenty-nine of them.

Mr. FLOOD. In your budget justification, you state that these 230 jobs will administer 6,000 grants totaling $1,400 million. Now, we are concerned about ratios again.

How does the ratio of staff to grants and dollars in your regional office compare to the ratio of staff to grants and dollars in the programs that are not decentralized?

Dr. COOPER. I don't have the figure of that ratio.

Mr. FLOOD. Don't guess at that one. You could get hit over the head with that.

Dr. COOPER. Yes, sir.

We will make the correct determination. I want to point out that in the regional offices there is a total number of 1,343 people that actually execute all the programs. The 201 of the 230 are those who are allocated from my account and who are responsible for the overall director and management of all public health service activity in the 10 regional offices.

The staff which implement the programs are charged to the accounts of the health agencies that have decentralized programs. We will provide you with the ratio of numbers of grants to the number of total people administering the grants themselves.

Mr. FLOOD. The staffs, the grants, the people, and the dollars in the regional office.

Dr. COOPER. As opposed to headquarters.

Mr. FLOOD. All right, for the record, give us about one-half dozen comparisons of centralized extramural programs with the regional office ratio. That just says it a different way.

Dr. COOPER. Yes, sir. I would also like to qualify the numbers in that explanation to take into consideration activities that the regional health office does besides administering grants, such as the technical assistance provided to the States and counties. So I will give you both the overall ratio and compare that with the centralized extramural activity.

[The information follows:]

RATIOS FOR SELECTED CENTRALIZED AND DECENTRALIZED GRANT PROGRAMS, GRANT AWARDS—FISCAL YEAR 1974

Centralized grant programs

ADAMHA research grants:	
Number of grants awarded	2,376
Dollar value of grants awarded	$182,100,000
Man-years expended [1]	181
Number of grants awarded per man-year	13.1
Dollar value of grant awards per man-year	$1,006,000
HRA health services research grants:	
Number of grants awarded	216
Dollar value of grants awarded	$28,400,000
Man-years expended [1]	81
Number of grants awarded per man-year	2.6
Dollar value of grant awards per man-year	$351,000
NIH training grants:	
Number of grants awarded	4,409
Dollar value of grants awarded	$195,900,000
Man-years expended [1]	158
Number of grants awarded per man-year	27.9
Dollar value of grant awards per man-year	$1,239,000

See footnote at end of table p. 455.

HSA maternal and child health research and training grants:	
Number of grants awarded	103
Dollar value of grants awarded	$23, 500, 000
Man-years expended [1]	28
Number of grants awarded per man-year	3. 7
Dollar value of grant awards per man-year	$839, 000

Decentralized grant programs

Maternal and child health services—formula and project grants:	
Number of grants awarded	460
Dollar value of grants awarded	$212, 145, 000
Man-years expended [1]	34
Number of grants awarded per man-year	13. 5
Dollar value of grant awards per man-year	$6, 239, 000
Community mental health services—staffing and project grants:	
Number of grants awarded	819
Dollar value of grants awarded	$192, 414, 000
Man-years expended [1]	72
Number of grants awarded per man-year	11. 4
Dollar value of grant awards per man-year	$2, 672, 000
Health manpower—project grants, capitation grants, loans, scholarships:	
Number of grants awarded	2, 387
Dollar value of grants awarded	$390, 418, 000
Man-years expended [1]	169
Number of grants awarded per man-year	14. 1
Dollar value of grant awards per man-year	$2, 310, 000
Community health project grants:	
Number of grants awarded	592
Dollar value of grants awarded	$330, 819, 000
Man-years expended [1]	99
Number of grants awarded per man-year	6. 0
Dollar value of grant awards per man-year	$3, 342, 000
Family planning service project grants:	
Number of grants awarded	316
Dollar value of grants awarded	$133, 747, 000
Man-years expended [1]	41
Number of grants awarded per man-year	7. 7
Dollar value of grant awards per man-year	$3, 262, 000

[1] This item represents an estimate of the effort of both grants management personnel and program personnel (and their respective support staffs) in the award of selected type grants.

Mr. FLOOD. For those programs that are decentralized we want to know how many people are employed in the central office in a supportive capacity to the regional office. I will tell you what we are worried about. I am trying to find out if this is a one-to-one ratio as we find in some departments or is it two to one or some other ratio? From the setup of yours it appears that the regional office may not be adequately staffed to do an effective job maybe.

Dr. COOPER. I understand. We will provide the data.

[The information follows:]

DISTRIBUTION OF POSITIONS BETWEEN CENTRAL AND REGIONAL OFFICES FOR SELECTED DECENTALIZED PHS PROGRAMS, FISCAL YEAR 1975

	Central office	Regional office	Ratios
Family planning	42	67	0.6 to 1.
National health service corps	42	60	.7 to 1.
Community health services	149	166	.9 to 1.
Maternal and child health	53	48	1.1 to 1.

DECENTRALIZATION OF PHS PROGRAMS

Mr. FLOOD. Are you planning to decentralize any additional PHS programs in 1976?

Dr. COOPER. Not at the moment.

Let me qualify what I just said.

There is a new program that was signed into law on January 7, the National Health Planning and Resources Development Act of 1974 which will have considerable regional activity because of the nature of the activity.

We are implementing it now.

Mr. FLOOD. There has been a lot of talk about that. Would you say these decentralization programs are successful in terms of improving the management of our grant program?

Dr. COOPER. Yes, for some.

Mr. FLOOD. All right. Mr. Conte?

Mr. CONTE. Pursuing that line of questioning, Dr. Cooper, there seems to be a problem or a conflict between the administrative control of the regional offices and the budgetary control of the agencies and institutes through which these appropriations are channeled.

The reports that I have seen show that this is a particular problem with some of the mental health programs. Would you mind commenting on that situation?

Dr. COOPER. I'm aware of the conflict that has existed between headquarters personnel of specific programs and the regional staff.

I think this has improved in the last year as the work plan of the regions has become implemented and the definition of roles has become clearer. I think there had been a natural reluctance of the headquarters personnel to relinquish the control over the operations until they were convinced that a staff was in the regions that would manage the programs as well as they conceived they handled it before.

In different programs there has been greater competition between the two staffs. It is my perception over the past year that as the roles have been defined and as the training programs have been instituted for the regional staff, as guidelines have been drawn as to who is responsible for the review process and who is responsible for the award process, that this overlap in functions has continually been reduced.

I would not be candid if I did not say, however, in some programs there is still some strong competition between the two staffs.

NATIONAL HEALTH INSURANCE

Mr. CONTE. In your statement, Dr. Cooper, you mentioned the second theme in your forward plan dealing with national health insurance. Do you have any indication of what kind of increased demands in our health care system might result from the adoption of a comprehensive health care insurance plan?

Dr. COOPER. There have been studies made by different groups, both within the Government and privately, of what a comprehensive health insurance program would mean in the sense of need for a capacity both for institutional care and ambulatory care. These have ranged between an 8- and 25-percent increase generally.

We estimate in our office of planning and in the Department's Planning Office toward the lower side. We think the demand for institutional care will be in the order of perhaps 10 or 12 percent because one of the good features of most of the proposals, including the administration's proposal of last year, is that it would encourage ambulatory care where it is appropriate rather than force people into institutions for services that could well be rendered in doctors' offices, in clinics, and in outside diagnostic facilities.

So I think there will be some increased demand but it will not be a massive demand.

Mr. CONTE. Well, I am pleased to hear you say that. It troubles me greatly. Everybody talks about national health insurance. It comes out very glibly. I wonder sometime whether we are putting the cart before the horse when we do not have the personnel to really care for these people.

Dr. COOPER. The reason we included that theme in our analysis is because we think there is a need for capacity building.

We think the solution to the health care problem is not solely refinancing. There is also a need to build a greater capacity in our health-care system. More important, in aggregate numbers in many respects, is the need to change the mix and location of resources, both in people and communities.

We will need a little time to implement these kinds of changes.

Mr. CONTE. Could you for the record elaborate on the actions which need to be taken in order to assure access of all members of society to health care at a reasonable cost?

Are you taking such actions and when do you think we could adequately cope with the demands induced by national health insurance. Put that in the record.

Dr. COOPER. Yes, sir. I will be glad to do it.

[The information follows:]

Enactment of a national health insurance program with universal coverage of the population for a comprehensive range of services would, of course, do much to assure financial access to health care. For the 30 million or so people who now have no health insurance and the millions more with inadequate coverage, this would be a significant advance. With the appropriate financing structure—one that establishes an optimum balance between out-of-pocket expenditures and prepayment—and with the opportunity provided by a national program to control overall health-care costs we think that such a program could go far toward making health care available to all at a reasonable cost. The basic features of the comprehensive health insurance plan that the administration introduced last year would, we think, achieve this. We are expecting to introduce national health insurance legislation early next year. Other efforts directed toward the cost of health care include the Department's sponsoring of research and experimentation in alternative reimbursement mechanisms that can be used to help contain costs not only in the present system but under the national health insurance.

Other problems related to access, however, are not best addressed through financing mechanisms alone. Thus, the Public Health Service currently administers health service project and formula grant programs that are directed toward capacity building in underserved and geographical scarcity areas. The National Health Service Corps is another example. We also have ongoing several major attempts to encourage more efficient service delivery and patterns of comprehensive care, such as development of health maintenance organizations, educational support for primary care manpower, and development of State and local planning and regulatory capabilities to move toward a more rational and efficient allocation of health-care resources.

The capacity building efforts I have just identified, as well as our programs in manpower education and training, represent major efforts to affect the distribution and allocation of resources as well as to develop the overall supply. As I mentioned, for a comprehensive program, estimates of increases in the demand for outpatient medical services range up to 25 percent. Corresponding estimates for manpower requirements range from 2 percent for allied health workers to 12 percent for physicians. Using these projections of supply needs and current growth rates, we estimate that within the next 5 years the physician supply should meet the demands of a comprehensive national health insurance program, if current policy with regard to foreign medical graduates continues. The supply of dentists, pharmacists, and nurses should be adequate in less time if current growth rates are maintained and if currently inactive professionals are attracted back into the market. In aggregate numbers, the supply of allied health workers should grow sufficiently rapidly to accommodate the small additional expected requirements, though in some of the many occupations included within this group the supply response may not be entirely adequate in the short run. As I mentioned earlier the demand for hospital services is not expected to increase significantly and may in fact decrease slightly under many of these proposals. Thus, the Nation's aggregate supply of short-term hospital beds should be adequate to meet anticipated demand. I should mention that these estimates represent supply requirements for a mature program when people have adapted their utilization of health services to the new benefits and do not reflect needs for a possible sudden but short-lived surge in demand at the start of the program.

In summary, resources are growing far faster than demand, even if comprehensive health insurance is enacted. There will be selective and important problems, particularly in underserved areas, just as there are today. We are seeking to address these issues through other programs, as I've mentioned. While the distribution problems are tough ones to solve, it is clear that resource constraints should not serve to retard the enactment of a comprehensive plan. Indeed, the availability of insurance protection in underserved areas will serve to provide an added economic incentive to attract more providers to these areas. Furthermore, it is important to emphasize that a plan that either concentrates only on catastrophic protection for the majority plus very broad coverage with minimal cost-sharing for low-income persons or one that removes cost-sharing entirely could exacerbate our resources problems, not help to correct them.

REGIONAL HEALTH ADMINISTRATORS' WORK PROGRAM

Mr. CONTE. Will you explain what you mean on page 4 of your statement concerning the regional health administrators program? What is this program, and what does it do, and how does it help you to relate resources to priorities?

Dr. COOPER. The work plan is a document which describes the relationship of the decentralized programs to each other and to the agencies they are derived from, since their budgets are included in the agencies appropriations.

The work program provides a structured process by which the regional offices receive guidance from agencies on what the objectives are, what resources are going to be allocated for the attainment of the objectives, and what the expectations are for the coming fiscal year.

It gives the regional office the opportunity to meld the series of programmatic objectives into an overall specified health response. By that we mean that there is a need to make sure that related programs that have different titles are applied toward the same objective.

A good example fo this is in the rural health field. There are several programs that are mandated under different laws and in different agencies which have the objective of improving the health services in the rural setting. It is important for the regional health administrator in dealing with the people in the region that they serve to be aware that there are several different related programs that their communities might compete for.

When they respond to a call from a given community or institution about rural health, they just do not answer, "The only program we have is the national health service corps or the program in the health resources administration," et cetera. So the relationship of agency programs each to the other ought to be grouped by health objectives. This work plan provides the framework under which these kind of related activities are put together so that the regional health administrators can serve those communities in a more organized fashion.

In that way we can track the improvement in services in an organized way and report back the number of people being served rather than the number of grants given.

Mr. CONTE. Good. Can you go one step further and find whether there are duplications there and come back to the Congress and tell us?

Dr. COOPER. Yes. I recently met with the regional health administrators. We have the health administrator from region 1 in Boston with us here today, Dr. Hunter. We discussed a situation arising wherein an announcement would be made for competition for programs for which applications had been reviewed. The work program provides us with a good mechanism for a public health official to be on top of the program in the field.

GRANT MANAGEMENT POLICIES

Mr. CONTE. You mentioned the updated set of grant management policies. Can you tell us some of the weaknesses of the present grant management system and how you propose to strengthen these areas?

Dr. COOPER. There was a great deal of criticism recently by this committee and other committees about the misuse of contracts or inappropriate use of contracts as opposed to grants.

It became important that we decide on what criteria would be used when a program is implemented—should it be a grant program or should it be a contract program. So these new guidelines and standards were developed for that purpose on the one hand.

Second, there were complaints at the same time challenging the adequacy of review of different instruments or different programs, that the peer review process was being applied very strongly in one agency but not in the other. We have therefore established norms which all the agencies are expected to meet, for insuring adequate, fair, and equal review of all applications, both in grants and contracts. I think it has been this kind of rectification of not malicious deficiencies, but insuring that as the new programs in the various health agencies are implemented, that the right instruments for support are applied and implemented in the correct way.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. CONTE. When do you foresee the total national coverage of PSRO's?

Dr. COOPER. We have Mr. Weinman with us here at the end of the table. The original plan of financing as well as implementing regulations has not been achieved on its original basis.

We have 91 in planning now. We have 13 conditional and 13 support centers. Maybe Mr. Weinman can comment on the projections for the following years and when we will reach 203.

Mr. WEINMAN. I would guess it would probably be calendar year 1977 or 1978 based on the present financing and the speed of implemention.

I think we are making good progress. In June we will convert somewhere between 35 and 40 of the present plans which will give us a total of about 55 conditional professional standards review organizations. We also hope to let another 20 planning contracts in order to keep the momentum. It is very clear, based on our present available resources and what we estimate the cost of the program to be, that we will not be able to implement the 203 PSRO's as hoped, certainly not as soon as January 1976. I think it will go to 1977 or 1978 based on present projections and the present administration request.

Mr. CONTE. Are you the top administrator on PSRO?

Mr. WEINMAN. No, sir, I am the Deputy Director.

Mr. CONTE. Let me ask you a question.

We have an excellent PSRO group.

Mr. WEINMAN. That is Western Massachusetts.

Mr. CONTE. That is right. Because this group covers four counties with different populations the PSRO's have provided for representation on the board from each of the counties.

I understand such a provision is in violation of your regulation. I wonder if you could tell me why. This is a group which has enthusiastically embraced the PSRO concept; I think one of the first. They want to make sure each area is represented on the board. I cannot see anything wrong with that.

Mr. FLOOD. What is your name?

Mr. WEINMAN. David Weinman.

Mr. FLOOD. How long have you been on board?

Mr. WEINMAN. In this program, 16 months.

The issue is one of what we call "slotting," the seats on the board, whether you can have so many seats allocated for so many groups or so many geographic areas. The first policy was that we did not think it would be consistent to slot groups and that every doctor should have equal access to the positions on the board.

We are now going back to review that policy based on considerations raised by Western Massachusetts and a number of other PSRO's.

We want to be sure there is equal access to board membership for all PSRO doctors. The question is whether you can do this more equitably than we have done it and still have various groups and geographic areas represented.

Mr. FLOOD. It seems unfair if you have them all from one county. You could have better balance and get greater enthusiasm and interest on the board.

Mr. WEINMAN. I think the Chairman might remember some of the OEO community action situations in terms of board representation. I think there are some analogies there.

INSPECTION OF NURSING HOMES

Mr. CONTE. Did the chairman ask you what your nursing home affairs office found in their inspection of 295 nursing homes?

Dr. COOPER. No; he did not at this time. We commented on that briefly at the overview hearing. We have Dr. Abdellah with us. We would be pleased to comment on them now if you would like to hear a brief summary.

Dr. ABDELLAH. I think the greatest lesson we have learned from the survey is that we need to take a hard look at the total survey certification process.

At the moment assessment of facilities is in terms of the facility and not in terms of the services delivered to patients and residents. We are going to try to turn around the whole assessment approach to emphasize patient care.

For the first time we include a quality assessment instrument in our survey and found we could get good data about the patients and residents, concerning their health, nutritional status, pharmacy, and physical therapy services, et cetera. We feel there is much that needs to be done in terms of providing quality health care in these facilities.

We were encouraged by what we found in relation to fire safety. During these past 2 years we have undertaken an intensive effort to try to work with State surveyors and have provided training for fire marshals in fire safety. Although a number of facilities still have deficiencies, many of these could be corrected without major outlays or investment.

We feel we are a lot closer to developing a measure to grade these facilities just as you would grade restaurants A, B, and C. In addition, we hope to develop a system that would have some meaning in terms of the quality of care and also the environment in which these services are provided.

We found from the survey that there is a great deal that needs to be done in the area of costs and fiscal management.

We are now developing regulations dealing with uniform cost accounting procedures that will be mandated in July 1976.

We learned from the survey that several loopholes encouraging fraud such as the rentals and the change of ownership can be avoided by improving the reporting system and monitoring the States' effort more closely.

Mr. CONTE. It sounds like you have made some progress.

Mr. ABDELLAH. Yes, sir, we have.

Our full report of the survey will be available next month.

NURSING HOME REGULATIONS

Mr. CONTE. We have received some charges in our office. Nursing home regulations are being more strictly enforced, if that is the correct way of putting it, in New England and particularly Massachusetts than any other part of the country. Can you provide any evidence to deny or affirm these charges and can you provide statistics to indicate enforcement levels in other parts of the country?

Dr. ABDELLAH. The Secretary and Dr. Cooper have both stressed the importance of uniform enforcement procedures. We work very closely with the ten regional offices of long term care standards enforcement. We have an interagency policy advisory group on long term care to make sure policies are interpreted uniformly. The recent deadline of March 15 regarding certification of intermediate facilities was enforced across the board uniformly.

We worked with the regional offices to provide whatever technical assistance was required to assure the safe relocation of patients and residents.

Mr. FLOOD. I migh say with Frank Carlucci up in Pennsylvania the Pennsylvania people would not agree with you about that.

Mr. CONTE. They are pretty rough up there. Well, I don't know but we are getting complaints in our office.

Dr. ABDELLAH. It is important to recognize that most of the new regulations deal with improvement of health and quality of care. We feel these standards are a minimum and they should be met.

Mr. FLOOD. How long have you been running that shop?

Dr. ABDELLAH. Since November of 1973.

LONG-TERM HEALTH CARE FACILITIES

Mr. CONTE. There seems to be a real shortage of long-term health care facilities in many parts of the country. In Massachusetts patients are kept longer than necessary at considerably high costs in the hospitals because there is no alternate care institutes there. Has your office done any work in this area and do you have any ideas for any solution to this problem?

Dr. ABDELLAH. One approach that we used, and your State was very instrumental in helping us move in that direction, was to institute a regulation permitting the patients and residents to take 3-day furloughs to spend at home or have a checkup in a hospital. We were able to work out an approach with the medical service administration whereby the facility would hold the bed while the person was on furlough.

Such furloughs could be taken 3 to 6 times per year. This has been quite a successful approach.

We are also moving quite vigorously in the area of developing home health services programs.

We feel this is a viable resource that has been untapped and is a useful alternative to institutional care.

About one-third of the patients and residents in nursing homes might do well in a home health-care-type service. This is something we would like to encourage.

HEALTH POLICY BOARD

Mr. CONTE. Could you tell me about the work of the health policy board, what it is doing and what it will be doing in the coming year? year?

Dr. COOPER. Yes. We will provide that information for the record.

[The information follows:]

The Health Policy Board is my internal executive staff committee. It is composed of the Acting Deputy Assistant Secretary for Health, the six agency heads, and the key staff office directors. This Board meets every 2 weeks to review and advise me on major policy and program decisions, particularly those which affect more than one agency. The Board, for example, is actively involved in reviewing policy issues surrounding the recently enacted National Health Planning and Resources Development Act. It advises me on all phases of the forward planning process including selection of major issues for in-depth analysis, consideration of long-range PHS strategy and direction and it makes recommendations on resource allocations, new program initiatives and legislative proposals. It also serves as an arena for discussion of management programs common to all agencies, such as executive development, equal employment opportunity, and manpower management. The Health Policy Board thus serves as a means by which I can assure that the best thinking of key PHS officials can be directly brought to bear in determining the policy and program direction of the Public Health Service.

Mr. FLOOD. Mr. Patten.

Mr. PATTEN. In the year you were born in the State of New Jersey the only kind of State institutions were for the mentally ill or TB. There was no social security or old-age assistance. I ran around in 1931 getting releases for those who owned real estate. There was a Mrs. Manton who had a big house in Cranbury with old people there. I remember going around to these places. They served a need. Our newspapers are now full of stories about nursing homes. They have been all over the lot. We have State legislative investigating committees of old-age homes.

Speaking of the quality care, I remember in the early days it was really amazing what some of these women did on their own initiative to give people therapeutic treatments.

Someone came along and said, you have to have a medical license, you cannot do this. We passed the bills here. In New Jersey even a practical nurse had to be licensed. It was common in our neighborhood if you had a baby to hire someone to stay in the house 5 days to do the cooking and washing. You wouldn't want to go back to that, would you, for quality care?

Dr. COOPER. I would not want to eliminate it as a possibility. As Dr. Abdellah said, there are some elements of home care that we would like to encourage. We think one of the resources are good people, themselves. We are not opposed to good quality care by people and their families. We are concerned about the bad press that paints everybody with a broad brush in these scandals that have to be pointed out and dealt with.

Yet, I think there is a common ground where good care can be rendered by responsible persons in a home setting.

Mr. PATTEN. I am wondering under your five-point program, when we get to specifics, what it will look like. It seems to me I have been in this game all my life. I remember in the 1920's trying to get a venereal clinic at the local hospital. The doctors opposed me bitterly. They said it was socialism. We had at least 800 cases we could identify. There was no drive in the community to do anything about it.

Your budget has increased over 110 percent higher than 1970—the Office of the Director.

Everybody points out to this being the big budget, the HEW budget. It is certainly in the thousands of millions. I do not mean NIH, I am talking about this committees total budget. I think it is over $119 billion.

They are putting a lot of these small nursing homes out of business because there was a couple of fires. A fellow was in my office Saturday and said, "Ed, I am looking around. I have to put Mom in a nursing home." This fellow is full of pep. He is in business, makes $15,000 a year and has a wife and family. He said, "It looks like I will have to spend $12,000 to put her in a nursing home." I sat and talked to him. I could not come up with anything better. I said, "I don't know how you are going to do it." He cannot come in under most programs. He is not on welfare. We used 400 beds at Roosevelt Hospital as a nursing home which used to be for TB. That is up to $700 a month now and he is not eligible.

When you said we are going to look over the cost, in my years on this committee I have not seen any results to reduce the cost of eyeglasses. They still want $70. That is half their social security check. I don't know where we have made any gains on the cost for the 85 percent of my people who work every day.

They are never eligible for veterans' benefits, old enough for social security, eligible for welfare. The year you were born we had an overseer of the poor in our town. When we had all that unemployment in 1931, there was no State welfare department. We had many suicides. I'm not in favor of going back.

Dr. COOPER. I am not in favor of that solution, either.

Mr. PATTEN. If somebody can make some progress on costs so as to consider a fellow who goes into the factory every day and does the right thing and has $10,000 or $20,000 in the bank. He is thrifty and works hard and is a good citizen. I cannot get a handle on where I do anything for him specially, in these areas, like the nursing home. It is a tough problem.

Take public housing. I am loaded with public housing in Perth Amboy. Most of the people I grew up with are not eligible. You cannot make over $7,000 a year. That is even for senior citizens. If you have $10,000 in the bank, you are not eligible.

Doctor, you have a forward-looking plan for next year. It will be interesting to see what you come up with.

Dr. COOPER. We have some plans to contain the runaway growth of that problem.

Mr. PATTEN. Good luck to you.

Mr. FLOOD. I see, Doctor, you are about to leave the club. You are going to quit the actors.

Mr. PATTEN. We are going to see if the Senate consents.

Mr. FLOOD. If you have trouble in the other body and want some witnesses, come over here.

Dr. COOPER. I appreciate that.

Mr. FLOOD. We certainly agree with the proposal.

Dr. COOPER. Thank you.

Mr. FLOOD. Mr. Michel.

REGIONAL OFFICES

Mr. MICHEL. In terms of your regional operations, how do you insure that the health programs meet the particular health needs of the people in the region?

Dr. COOPER. Our regional offices have a variety of means of insuring that the health needs of the people in the region are addressed. Since 1966 the regional offices have worked closely with State and areawide comprehensive health planning agencies which have shared the primary responsibility for identifying health needs of the people. We have provided not only financial support to these agencies, but also technical assistance. The plans formulated by these agencies are basic reference tools for regional offices to help insure that the PHS programs are responsive to the needs identified in the plans. Under the National Health Planning and Resource Development Act of 1974, the role and authority of State and area agencies will be expanded, including the authority to review and approve most federally funded projects for service delivery.

The regional office staff through their close working relationships with State and local health officials are able to assess and analyze existing health resources and particular health needs. Most recently, they have been called on to assess and address health manpower needs.

Firsthand observations of the operation of federally funded health programs provides further opportunity to regional PHS staff to be sensitive to the health needs and the delivery of the health services to the people of the region. One region has instituted, under the leadership of its regional health administrator and its office of State coordination, an annual conference in which regional staff go to States and localities to discuss with public and private groups their ideas and views of health needs and methods of meeting the needs. Similar deliberate efforts to help assess and address the needs of the people in the region can be found in all regional offices, but the mechanisms are purposefully not stereotyped so that regional offices can be most responsive to their own constituencies.

Mr. MICHEL. What is being done in the regions to improve coordination with State and local health agencies?

Dr. COOPER. Some highly encouraging activities are being pursued to improve coordination with State and local health agencies. The reorganization of the PHS regional offices as well as the clarification of authorities delegated to the regional health administrators (RHA) have enhanced the ability of the RHA to coordinate overall PHS efforts in the region and, therefore, with State and local health agencies. Each PHS regional office has established an office of State coordination with the specific intent to strengthen these coordination efforts. Efforts are being initiated to identify the common denominators among programs with respect to technical assistance and evaluation so that these activities also may be better coordinated at the point of delivery with respect to State and local agencies.

In addition, individual health programs are built around the need to work closely with State and local health officials. For example, a major effort is underway through the cooperative health statistics system to formulate compatible health statistics systems at the local, State, regional, and Federal levels. The new National Health Planning and Resources Development Act of 1974 calls for establishment of local health service agencies and State health coordinating councils, with which we will be working very closely in the coordinated planning and implementation of health programs responsive to local and State needs and priorities.

In many of our programs, procedures for the submission of applications for Federal funds provide opportunity for State and local input in the review process. There are also procedures in place to provide notification to the States of all grant awards. The regional staff of the Public Health Service also work closely with the HEW regional directors, in such activities as participation in the Federal Regional Council, to insure coordination of all HEW programs at the State and local levels.

Mr. MICHEL. You indicate that the regional staffs have an impact on approximately 6,000 grants totaling $1.46 billion and involving 44 health programs. How are these funds monitored?

Dr. COOPER. Authority for the implementation of these 44 PHS programs has been delegated to the 10 regional health administrators—

RHA—who therefore have the full responsibility for review, approval, funding, and monitoring of all awards made under these various authorities. A variety of processes are used to monitor grant projects. These include the regular review of required grantee reports covering such areas as program progress and expenditures, the provision of professional and technical consultation as appropriate, periodic reviews of program as well as management activities of the grantees. Regular site visits are normally conducted annually, but may be more frequent if necessary. Depending upon the size, complexity, and possible problems, these site visits may be made by teams of regional office staff having special expertise in required areas, such as administration, the various health professions, as well as in-depth knowledge of the program and specific project. Of course, the primary vehicle for assuring the programatic and fiscal integrity of the projects funded by the PHS regional office is the annual funding cycle, which requires an in-depth review of the status of the project as well as project plans contained in the request for refunding.

Mr. MICHEL. How many people are employed on the regional staffs throughout the country?

Dr. COOPER. There are 1,343 PHS employees assigned to the 10 regional offices.

Mr. MICHEL. How many people are involved in program direction and support services?

Dr. COOPER. A total of 436 positions, the same as in 1975, are included in the 1976 budget request for program director and support services.

INTERNATIONAL HEALTH EFFORTS

Mr. MICHEL. What are some of the international health efforts you plan for fiscal year 1976?

Dr. COOPER. Our international efforts in health for 1976 include a continuation of our ongoing programs, and an expansion into new areas.

The ongoing activities include a major input into the activities of the World Health Organization and other member organizations of the U.N. family, through our participation in their meetings, expert committees, et cetera. Through such cooperation with international organizations involved in the health field, we are able to participate in a worldwide sharing of knowledge in many areas, as well as contributing to international collaborative efforts designed to eradicate diseases which are of interest to all countries.

We are also actively involved in promoting collaboration in health research with many other countries. This research includes basic biomedical activities, as well as investigation into health delivery systems and methods of financing of health care. Some of this research is funded under the special foreign currency program, Public Law 480. In many cases, however, the collaborating country and HEW finance the research independently, and then share the results through joint meetings and symposia.

The Public Health Service also makes a major technical contribution to the Agency for International Development through assistance in health planning and health sector assessments for other countries. Knowledge gained through this activity in different settings is of use to the domestic agencies in improving their capacity to respond to the many health problems facing us in the United States today.

Some of the newer activities for fiscal year 1976 have developed as a result of recent initiatives by Secretary of State Kissinger in establishing joint commissions with several countries—especially in the Middle East. As health is one of the areas in which countries such as Egypt, Iran, Saudi Arabia, and India have expressed interest, we have begun to develop collaborative activities with them and expect to expand these during fiscal year 1976.

Mr. MICHEL. You mention specifically in your statement, several countries with whom we have strengthened bilateral health programs? Are these five countries—the U.S.S.R., Poland, Mexico, Japan, and Romania—the only countries with whom we are presently working to strengthen our cooperative programs?

Dr. COOPER. No. We are also actively involved with many other countries.

For several years, we have had close collaboration with Canada, the United Kingdom, France, Yugoslavia, and many other countries. We meet, for example, twice a year with our counterparts in Canada and the United Kingdom to discuss problems of mutual interest and concern. The National Institutes of Health has an excellent cooperative program with the National Institute for Health and Medical Research (INSERM) of France, and we have extensive programs between all of the health agencies and Yugoslavia which have been ongoing for many years. I also mentioned, a few minutes ago, our involvement with the Middle East countries through their joint commissions.

Mr. MICHEL. Of those five countries mentioned, what is the major emphasis of each in terms of health research planning and how much money does each country spend towards health, both in terms of dollars and as a percentage of their total national budget?

Dr. COOPER. We will supply a table for the record which will provide that information.

[The information follows:]

The following table shows the major areas of research emphasis, the level of national health budgets in dollars, and the percentages that these health budgets represent of total budgets, for several countries.

[In U.S. dollars]

Country	Major emphasis of health research	Health budget and percent of total budget [1]
Romania	Cancer, environmental health, child development, respiratory diseases, problems of the aged, cardiovascular diseases.	$700,000,000 and 4.5–5 percent of total.
Poland	Environmental health, occupational health, mental health, maternal/child health, rehabilitation circulatory diseases, evaluation of health status of population.	$1,660,000,000 and 7.8 percent of total.
U.S.S.R.	Cardiovascular diseases, virus diseases, cancer, accidents, treatment/rehabilitation of patients suffering from the above diseases and conditions.	$15,000,000,000 and 5.4 percent of total.
Japan	Cancer, cardiovascular diseases, maternal/child health, communicable diseases, environmental pollution.	$970,000,000 [2] and 1.3 percent of total.
Mexico	Nutrition, population, environmental pollution	$242,000,000 [2] and 7.2 percent of total.

[1] Figures shown are for the most recent period and represent expenditures of the National Government only.
[2] Figures represent expenditures of the Ministry of Health but not those of the social security system in the health sector or those made by local and regional levels of Government or private sources.

OFFICE OF PROFESSIONAL STANDARDS REVIEW

Mr. MICHEL. What role does the Office of Professional Standards Review play in the development of the PSRO program since, as I understand, that program is being transferred to the Health Services Administration.

Dr. COOPER. Yes; the funding for the PSRO program is being transferred to the Health Services Administration (HSA. However, the Office of Professional Standards Review (OPSR) is still a part of my office and is responsible for the coordination of the Department's overall PSRO effort. As you know, in addition to the HSA involvement in the PSRO program, the Medical Services Administration of the Social Rehabilitation Services and the Bureau of Health Insurance of the Social Security Adminstration are also an integral part of this new health initiative. In order to insure effective implementation and administration of this multiagency program, the OPSR provides the required coordinative mechanism from a single departmental focal point.

Mr. MICHEL. Thank you.

Mr. FLOOD. Thank you again, Doctor.

Dr. COOPER. Thank you, Mr. Chairman.

Justification of the Budget Estimates

Appropriation Estimate

ASSISTANT SECRETARY FOR HEALTH

For expenses necessary for the Office of the Assistant Secretary for Health, [$30,215,000, together with not to exceed $27,000,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein, to carry out, to the extent not otherwise provided, title XI, part B, of the Social Security Act][1] *$23,288,000.*

For "Assistant Secretary for Health", for the period July 1, 1976, through September 30, 1976, $6,302,000.[2]

Explanation of Language Changes

1. This language has been deleted to reflect the transfer of the Professional Standards Review Organizations activities to the Health Services appropriation.

2. Language has been added to permit implementation of the Congressional Budget and Impoundment Control Act of 1974 which changes the beginning of the fiscal year from July 1 to October 1.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Amounts Available for Obligation

	1975 Revised	1976
Appropriation	$30,215,000	$23,288,000
Proposed supplemental for pay costs	777,000	
Subtotal, adjusted appropriation	30,992,000	23,288,000
Comparative transfers to:		
"Health Services" Transfer of Professional Standards Review Organizations activities	-9,128,000	
"Health Resources" Transfer of Comprehensive Health Planning activities in regional offices	-824,000	
"Departmental Management" Transfer of administrative support for Project Start	-14,000	
Comparative transfers from:		
"Alcohol, Drug Abuse, and Mental Health" Transfer of costs of automated terminal communicating systems in regional offices	5,000	
"Health Resources" Transfer of administrative support for Upward Mobility functions and costs of automated terminal communicating systems in regional offices	68,000	
"Health Services" Transfer of costs of automated terminal communicating systems in regional offices	19,000	
"Preventive Health Services" Transfer of costs of automated terminal communicating systems in regional offices	3,000	

Amounts Available for Obligation

	1975 Revised	1976
"John E. Fogarty International Center for Advanced Study in Health Sciences"..... Transfer of costs of US-USSR joint committee for health cooperation activities	137,000	
"Human Development"..... Transfer of President's Council on Physical Fitness and Sports activity	558,000	
"Social Security Administration"..... Transfer of costs of Health Insurance Benefits Advisory Council activities	209,000	
Subtotal, budget authority.....	22,025,000	23,288,000
Total obligations.....	22,025,000	23,288,000

Summary of Changes

1975 Estimated obligations	$21,248,000
Plus: 1975 Proposed supplemental	777,000
Subtotal, 1975 Revised obligations	22,025,000
1976 Estimated obligations	23,288,000
Net change	+1,263,000

	1975 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
Built-in:				
1. Within grade increases	---	---	---	+$305,000
2. One extra day of pay	---	---	---	+65,000
3. PHS Service and Supply Fund costs	---	---	---	+84,000
4. Annualization of October 1974, health benefits costs	---	---	---	+299,000
5. Annualization of January 1975, health benefits costs	---	---	---	+35,000
6. Facilities service lease and users charges	---	---	---	+442,000
7. Increase in the telephone rates	---	---	---	+33,000
Total, net change	---	---	---	+1,263,000

Explanation of Changes

The total increase of $1,263,000 is required for the mandatory items listed above.

Obligations by Activity

Page Ref.		1975 Base Pos.	1975 Base Amount	1976 Estimate Pos.	1976 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
220	Regional Management	230	$6,434,000	230	$6,677,000	---	+$243,000
221	Program Direction and Support Services	436	12,782,000	436	13,705,000	---	+923,000
223	Health Care Assurance	87	2,251,000	87	2,328,000	---	+77,000
225	President's Council on Physical Fitness and Sports	12	558,000	12	578,000	---	+20,000
	Total obligations	765	22,025,000	765	23,288,000	---	+1,263,000

Obligations by Object

	1975 Estimate	1976 Estimate	Increase or Decrease
Total number of permanent positions..	765	765	---
Full-time equivalent of all other...	73	73	---
Average number of all employees.....	805	805	---
Personnel compensation:			
Permanent positions.....	$14,980,000	$15,586,000	+$606,000
Positions other than permanent....	727,000	738,000	+11,000
Other personnel compensation.....	136,000	137,000	+1,000
Subtotal, personnel compensation	15,843,000	16,461,000	+618,000
Personnel benefits.....	1,470,000	1,556,000	+86,000
Travel and transportation of persons	1,152,000	1,152,000	---
Transportation of things.....	51,000	51,000	---
Rent, communications and utilities..	1,889,000	2,364,000	+475,000
Printing and reproduction.....	166,000	166,000	---
Other services.....	1,203,000	1,287,000	+84,000
Supplies and materials.....	118,000	118,000	---
Equipment.....	133,000	133,000	---
Total obligations by object.....	22,025,000	23,288,000	+1,263,000

Assistant Secretary for Health
Salaries and Expenses

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1966...	$6,648,000	$6,648,000	$6,648,000	$6,648,000
1967...	8,207,000	8,069,000	7,648,000	7,858,000
1968...	9,087,000	8,358,000	8,358,000	8,358,000
1969...	9,073,000	9,073,000	9,073,000	9,073,000
1970...	9,898,000	9,898,000	9,898,000	9,898,000
1971...	12,636,000	12,636,000	12,636,000	12,636,000
1972...	12,497,000	12,497,000	12,497,000	12,497,000
1973...	20,519,000	20,519,000	20,519,000	20,519,000
1974...	22,658,000	22,658,000	15,354,000	20,354,000
1975...	22,432,000	22,312,000	21,248,000	21,248,000
Supplemental.	777,000			
1976...	23,288,000			

Assistant Secretary for Health

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	765	$17,313,000	765	$18,017,000	---	+704,000
Other expenses	---	4,712,000	---	5,271,000	---	+559,000
Total	765	22,025,000	765	23,288,000	---	+1,263,000
Activities						
1. Regional Management	230	6,434,000	230	6,677,000	---	+243,000
2. Program Direction and Support Services	436	12,782,000	436	13,705,000	---	+923,000
3. Health Care Assurance	87	2,251,000	87	2,328,000	---	+77,000
4. President's Council on Physical Fitness and Sports	12	558,000	12	578,000	---	+20,000
Total	765	22,025,000	765	23,288,000	---	+1,263,000

General Statement

This appropriation provides support for the administrative staff required to administer the PHS decentralized health programs, staff for the Assistant Secretary for Health, staff for the coordination of the overall National effort to assure the quality of and development of health care standards, and resources necessary for the continuation of the National physical fitness and sports program. The Assistant Secretary for Health is the principal advisor to the Secretary on health policy and all health-related activities for the Department, and is responsible for the direction of the Public Health Service agencies. He provides leadership and policy guidance for health and health-related activities for the people of the Nation, and for maintaining relationships with other governmental agencies, private agencies, and some international organizations concerned with health-related matters.

Regional Management

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	230	$4,938,000	230	$5,130,000	---	+$192,000
Other expenses	---	1,496,000	---	1,547,000	---	+51,000
Total	230	6,434,000	230	6,677,000	---	+243,000

The staff supported by this activity is located in the ten PHS regional offices and in the PHS Office of Regional Operations. The regional office staff supports the immediate office of the Regional Health Administrators, the principal health officials in the regions, who are responsible to the Assistant Secretary for Health. The staff of the Office of Regional Operations, located in headquarters, is the principal staff advisor to the Assistant Secretary for Health in matters pertaining to the operation of the PHS Regional Offices.

The Regional Offices activity involves an estimated 40 decentralized health programs funded by appropriations of four of the six PHS health agencies. Currently there are approximately 6,000 grants totaling $1.4 billion being awarded and administered in the regional offices.

In 1975, the Regional Management staff continued to provide the overall management capabilities necessary to administer the decentralized health programs in the ten regional offices. New procedures in operational planning and resouce management were implemented which placed new major responsibilities on the regional management staff. The overall system, known as the Regional Health Administrators Work Program, provides a structured process to mold program objectives into an integrated regional response that recognizes particular health needs in the regions. The system also permits constant monitoring of activities to assure implementation of objectives as well as necessary redirection of efforts responsive to changing priorities. This has been accomplished in close coordination with the health agencies personnel to assure accomplishment of categorical program objectives within the concept of an integrated health strategy in the regions.

The primary focus of Regional Management in 1976 will be to improve the Regional Health Administrators Work Program system which will enhance the regional offices capability to implement in a more effective manner their responsibilities as the operational component of the Public Health Service. In addition, a strong emphasis will continue to be placed on improving coordination with State and local health agencies, improving management support in such areas as grants and contracts administration and project monitoring as well as working with the HEW Regional Directors in coordinating all HEW programs in the regions.

An increase of $243,000 is required to provide for mandatory costs for within grade increases effective during the year, $71,000; annualization of the October 1974 pay raise, $93,000; annualization of health benefits costs, $10,000; one extra day of pay, $18,000; and $51,000 to be transferred to the General Services Administration for space rental charges.

Program Direction and Support Services

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	436	$10,141,000	436	$10,556,000	---	+$415,000
Other expenses.....	---	2,641,000	---	3,149,000	---	+508,000
Total.....	436	12,782,000	436	13,705,000	---	+923,000

This activity provides staff support for the Assistant Secretary for Health for guidance, leadership and direction to the Public Health Service Agencies on all health and health-related activities, including research and development; education and training; organization financing and delivery of health care services; provision of preventive health services; and protection to the public from unsafe foods, drugs, and medical devices.

This activity includes staff and related costs for the Immediate Office of the Assistant Secretary for Health, and the offices of Equal Employment Opportunity, Public Affairs, Health Legislation, Program Implementation, International Health, Administrative Management, and Policy Development and Planning. The following are some of the achievements and goals for fiscal years 1975 and 1976 for the Office of the Assistant Secretary for Health:

The program implementation functions were realigned in 1975 to more effectively serve as the focal point for advising the Assistant Secretary on operating problems, monitoring and coordinating the implementation of the various health activities of the Public Health Service. This includes the development of implementation plans for new health programs, management of an operational planning system, administering the National Environmental Policy Act, directing committee management functions, and coordinating patent appeals. A manual on the PHS Regulations Process was developed and issued and an Implementation Planning System was developed and installed to insure that new health legislation and initiatives are promptly analyzed and assessed to assure planned results. The operational planning system was redesigned to provide for monitoring and coordinating matters of high interest to both the Assistant Secretary for Health and the Secretary. These functions will continue in 1976 to aid in the implementation of new program policies and legislative mandates with particular interest toward the development of an umbrella system which will integrate all of the individual systems and the development of a microfilm correspondence control capability.

During 1975 technical assistance on international health matters was rendered to the Department of State, the Agency for International Development, the World Health Organization, the Pan American Health Organization, numerous international health and health-related organizations, Ministries of Health of many countries, and domestic organizations and individuals seeking advice on international health matters. Major accomplishments were made in the integration of international activities of the Public Health Service and its domestic programs and the coordination of policy and health functions between the various PHS Agencies and other Federal agencies involved in international health.

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Other accomplishments include the strengthening of bilateral programs between the United States and Ministries of Health of several countries; assisting the Agency for International Development by performing health sector analyses and health sector assessments, preparing comparison health documents on 15 countries and assisting in the design and technical review of health programs proposals; and providing major input into the activities of the recently formed Commissions in India and countries in the Middle East. Plans for 1976 involve principally a continuing contribution to improving the participation of the United States Government in international health activities. This will be through efforts to strengthen existing bilateral programs and our involvement with the World Health Organization and other international health organizations.

In the area of grants administration, a compendium of all PHS grant policies was issued, a grants management data system was implemented, and a booklet describing in detail the PHS grant programs was issued for general public use. The personnel management policies and procedures for implementation of the Department's Executive Development Program and personnel evaluation of field activities were completed along with establishing a PHS manpower data retrieval system. Initiatives underway in 1975 will be continued in 1976. Major emphasis will be placed on implementing Labor-Management Relations in the Federal Service and developing more effective ways of optimizing use of both the Civil Service and Commissioned Corps personnel systems to meet the manpower needs of the Public Health Service.

The Forward Plan through 1980 was prepared coordinating health strategies for special priority areas including child health, manpower resources, scarcity and mal-distribution of medical personnel, fair information health practice, and health prevention. Other accomplishments included policy development relating to comprehensive health insurance proposals, establishment of a uniform health data policy and provided direction for recommended new policies which will assure the confidentiality of medical records within Government, as well as in the private sector. In addition a committee was established to assess the impact of National Health Insurance on the health industry. Efforts begun in 1975 will be continued in 1976 with particular emphasis on coordinating research which encompasses experiments in ambulatory surgery and long-term care services.

In summary, a total of $13,705,000 is requested for the continuation of this activity. The net increase of $923,000 over the 1975 operating level of $12,782,000 represents mandatory costs for within grade increases, $198,000; one extra day of pay, $41,000; annualization of 1975 pay raises, $155,000; annualization of 1975 health benefits costs, $21,000; increase in telephone rates, $33,000; increased costs for PHS Service and Supply Fund, $84,000; and $391,000 increased costs of space rental charges to be transferred to the General Services Administration.

Health Care Assurance

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	87	$1,904,000	87	$1,981,000	---	+$77,000
Other expenses	---	347,000	---	347,000	---	---
Total	87	2,251,000	87	2,328,000	---	+77,000

The staff supported by this activity coordinates the overall Department's effort to set quality standards for health care. The activity oversees and organizes interagency communication on the development of all policies and procedures related to quality assurance and standards of health care, resolving controverted issues when possible, and surfacing unresolved issues for Secretarial decisions as needed.

This activity includes staff and related costs for the offices of Professional Standards Review (OPSR), Nursing Home Affairs and Population Affairs (OPA). Some of the achievements and objectives for 1975 and 1976 are:

By Secretarial request, OPSR provided overall direction to the Department's development, publication and implementation of new utilization review regulations for services paid for under the Medicare and Medicaid programs.

The Office took the lead in establishing a PSRO data systems task force, which completed the identification of uniform data requirements of the Professional Standards Review Organizations (PSRO) program and the design of a system for the collection, protection and transmission of PSRO data.

Evaluation and research accomplishments included the completion of an evaluation plan for the PSRO program; completion of an inventory of quality assurance research efforts within the Department; the design of a plan to conduct new clinical trials needed to determine the efficacy of selected medical procedures; and the development of program funding plans for fiscal years 1975 and 1976.

The OPSR mounted a concerted effort to instruct the medical profession on the nature of the PSRO program through a series of articles and interviews in the professional journals and through the circulation of informational materials throughout the physician community.

Finally, the initial design of a comprehensive technical assistance capability for all elements in the PSRO program was completed.

The OPSR will maintain its capacity to integrate key Departmental components on important issues in 1976, since the multiagency program will continue to require unified management from a single Departmental focal point.

Coordination of the implementation of the Utilization Review Regulations in hospitals across the country will continue as a major activity.

Implementation of the evaluation plan will begin, as well as implementation of a quality assurance research strategy, and conduct of a series of clinical trials to determine the efficacy of selected medical procedures.

Cooperation and coordination will be required with the Departmental units implementing the National Health Planning and Resources Development Act of 1974, as the need emerges to assure adequate communication between PSROs and the health systems agencies mandated by the Act.

As expertise is gained by PSROs in the review of acute care, the Office will put added emphasis on the development of effective methodologies for the review mandated by the legislation of long-term care and ambulatory care.

The Office of Nursing Home Affairs surveyed a randomly-selected national sample of 295 nursing homes involving some 3,500 patients, to gather baseline data to identify needs, to develop programs to meet those needs, and to measure the overall success of the Federal initiatives in this area. The Long-term Care Management Information System became operational during the early spring of 1975. This system provides instant information on surveys, certifications, life safety code inspections, termination of Federal funding and other matters of current nursing home concerns. Several publications pertaining to upgrading nursing home care and facilities were issued.

Efforts begun in 1975 to improve nursing home care and facilities will be continued in 1976 through intensive training of nursing home inspectors and the development of a method for grading nursing homes uniformly throughout the Nation. The current short-term training programs for surveyors and health provider personnel will be continued and multimedia training tools and innovative teacher-learning methodologies will be developed. A monthly cost-of-care index for each of the ten regional boundaries will be developed for use in the Bureau of Labor Statistics cost-of-living index.

During 1975 the Office of Population Affairs participated in the review and evaluation of proposed grants and contracts for population research and family planning services activities. The Department's annual report on "Population and Family Planning Activities" and the "Five Year Plan for Family Planning Services and Population Research Programs" were prepared as required by law. Some 4 million women received subsidized services through organized programs and many more received services from private physicians. An active role in formulating the Department's regulations concerning sterilization and family planning services provided Aid to Families with Dependent Children. In coordination with the Health Services Administration, plans are underway for the integration of family planning services programs into the general health care system. Family planning services and population research activities will be continued as a high priority in 1976.

In summary, a total of $2,328,000 is required for the continuation of this activity. The net increase of $77,000 over the 1975 operating level of $2,251,000 represents mandatory costs for within grade increases, $36,000; one extra day of pay, $6,000; annualization of 1975 pay raises, $31,000; and annualization of health benefits costs $4,000.

President's Council on Physical Fitness and Sports

	1975 Estimate		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	12	$330,000	12	$350,000	---	+$20,000
Other expenses	---	228,000	---	228,000	---	---
Total	12	558,000	12	578,000	---	+20,000

The staff supported by this activity conducts the national program of physical fitness and sports to promote private support for physical fitness and mass amateur sports development programs; conducts continuing public service information programs about the nature and extent of the physical fitness problem; provides technical services to State and local systems, recreation agencies, sports programs, fitness councils and youth-serving groups; coordinates Federal physical fitness activities and supervises a Federally funded sports program for economically disadvantaged youth.

During 1975 the Presidential awards program for adults was expanded, the number of governors and mayor's councils on physical fitness increased, evaluation of the national youth physical fitness was begun for the development of new norms, information and technical assistance programs were expanded and extended to new groups, and the private sector increased their support for a number of participation programs developed by the Council.

Plans for 1976 involve principally a continuing improvement of on-going programs and efforts. This will be through efforts to survey sports participation of American adults; development of additional private sector support for sport and fitness programs; extend the Presidential awards program to high-school-age youth; identify and develop support for needed physical fitness research; and to intensify endeavors to incorporate mass physical fitness, trim, and sports programs in the Nation's communities.

An increase of $20,000 over the 1975 operations level of $558,000 is to provide for full-year costs of the 1975 pay raise increase.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Regional Management

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
230	$6,434,000	Indefinite	230	$6,677,000

Purpose: This activity supports the immediate office of the Regional Health Administrators and a core headquarters regional advisory staff to the Assistant Secretary for Health. The Regional Health Administrators are the principal regional health officials responsible to the Assistant Secretary for Health for determing and implementing health policies, priorities, goals and objectives within the scope of national health policies.

Explanation: To provide funding for advisory, administrative and managerial support in the implementation of decentralized health programs funded by appropriations from four of the six health agencies.

Accomplishments in 1975: In 1975, new prodecures in operational planning and resource management were implemented to enhance the regional office capability to effectively carry out their responsibilities with regard to administering decentralized programs.

Objectives in 1976: The primary focus in 1976 will be to improve the new procedures in operational planning and resource management that became effective in 1975. Further, strong emphasis on improving coordination of health services with State and local health agencies and in the administration of grants and contracts will be a major priority objective.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Program Direction and Support Services

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
436	$12,782,000	Indefinite	436	$13,705,000

Purpose: This activity provides staff support for the Assistant Secretary for Health for guidance, leadership and direction to Public Health Service programs on all health and health-related activities, including research and development, education and training, organization, financing and delivery of health care services, preventive health care, and problems relating to unsafe foods and drugs.

Explanation: To provide funding for program direction and support services for the Assistant Secretary for Health.

Accomplishments in 1975: In 1975, the Forward Plan for Health was prepared and much effort was spent in the development of comprehensive health insurance proposals and other health policies and needs. Major gains were made in the integration of international activities of the Public Health Service and its domestic programs and the coordination of policy and health functions between the Health agencies.

Objectives for 1976: Particular emphases will continue to be placed upon the potential impact of changes in health care financing, and the health impact on State and local fiscal and regulatory roles concerning health manpower requirements. There will be continued efforts to develop coordinate, and implement health policies and practices to effect improved standards in the Nations health systems.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Health Care Assurance

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
87	$2,251,000	Indefinite	87	$2,328,000

Purpose: The staff supported by this activity is responsible for the development of National policies and procedures for quality assurance and health care standards.

Explanation: To provide funding for staff and related costs for Professional Standards Review, Nursing Home Affairs, and Population Affairs.

Accomplishments in 1975: Leadership was provided in establishing means for the identification of uniform data requirements of the Professional Standards Review Organizations (PSRO) programs and the design of PSRO data. Program funding plans and evaluation and research efforts were accomplished in order to carry out the PSRO program objectives. A national sample of 195 nursing homes involving some 3,500 patients were surveyed. Some 4 million women received subsidized family planning services through organized programs.

Objectives in 1976: In the area of Professional Standards Review, efforts will be accelerated in order to make the PSRO programs fully operative and of high quality. There will be continued efforts to improve nursing home care and facilities along with additional training for nursing home inspectors, surveyors, and health provider personnel.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: President's Council on Physical Fitness and Sports

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
12	$558,000	Indefinite	12	$578,000

Purpose: This activity supports staff engaged in conducting the national program of physical fitness and sports.

Explanation: To provide funding for the President's Council on Physical Fitness and Sports.

Accomplishments in 1975: In 1975, the Presidential awards program was expanded and State and local officials along with the private sector increased their support for a number of ongoing programs.

Objectives for 1976: The Presidential awards program will be extended to high-school-age youth, a survey of sports participation by American adults will be made, and additional private sector support for sports and fitness programs will be developed.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Amounts Available for Obligation

	1976 Estimate	Interim Budget
Appropriation	$23,288,000	$6,302,000

Obligation by Activity

	1976 Estimate		Interim Budget		
	Pos.	Amount	Pos.	Amount	
Regional Management	230	$6,677,000	230	$1,768,000	A/
Program Direction and Support Services	436	13,705,000	436	3,689,000	B/
Health Care Assurance	87	2,328,000	87	596,000	C/
President's Council on Physical Fitness and Sports	12	578,000	12	249,000	D/
Total	765	23,288,000	765	6,302,000	

A/ The funding level for this activity is projected at 25 percent of the 1976 estimate plus an additional requirement of $96,000 for mandatory items and normal first quarter costs not recurring in the remaining three quarters.

B/ The funding level for this activity is projected at 25 percent of the 1976 estimate plus an additional first quarter requirement of $261,000 for mandatory items and a one time annual payment to the General Services Administration for rental of space.

C/ The funding level for this activity is projected at 25 percent of the 1976 estimate plus additional mandatory costs of $13,000.

D/ The funding level for this activity is projected at 25 percent of the 1976 estimate plus an additional $99,000 for mandatory costs and first quarter costs associated with a one time annual contract.

Obligation by Object

	1976 Estimate	Interim Budget
Total number of permanent positions	765	765
Full-time equivalent of all other positions	73	19
Average number of all employees	803	202
Personnel compensation:		
Permanent positions	$15,586,000	$3,998,000
Positions other than permanent	738,000	186,000
Other personnel compensation	137,000	35,000
Subtotal, personnel compensation	16,461,000	4,219,000
Personnel benefits	1,556,000	435,000
Travel and transportation of persons	1,152.000	288,000
Transportation of things	51,000	14,000
Rent, communications and utilities	2,364,000	740,000
Printing and reproduction	166,000	42,000
Other services	1,287,000	500,000
Supplies and materials	118,000	30,000
Equipment	133,000	34,000
Total obligations by object	23,288,000	6,302,000

WEDNESDAY, APRIL 23, 1975.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

WITNESSES

JAMES D. ISBISTER, ACTING ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
DR. MORRIS E. CHAFETZ, DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
DR. ROBERT L. DuPONT, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE
DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH
JOSEPH R. LEONE, ACTING EXECUTIVE OFFICER, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
JOHN D. MAHONEY, ACTING DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT, ALCOHOL, DRUG ABUSE, AND MENTAL ADMINISTRATION
JOHN A. DEERING, ACTING DEPUTY DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
MARTIN K. TRUSTY, EXECUTIVE OFFICER, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
KARST J. BESTEMAN, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE
JOHN M. PROCTOR, EXECUTIVE OFFICER, NATIONAL INSTITUTE ON DRUG ABUSE
DR. THOMAS F. A. PLAUT, COUNSELOR TO THE DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH
JAMES E. PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
DR. FRANCIS N. WALDROP, DIRECTOR, DIVISION OF MANPOWER AND TRAINING PROGRAMS, NATIONAL INSTITUTE OF MENTAL HEALTH
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLOOD. We now have the Alcohol, Drug Abuse, and Mental Health Administration. The presentation will be made by James D. Isbister, the Acting Administrator. The biographical sketch will be placed in the record at this point.

[The biographical sketches follow:]

CURRICULUM VITAE

JAMES D. ISBISTER

Birthplace and date: Mt. Clemens, Mich., March 31, 1937.
Marital status: Married, two children.
Education: University of Michigan, B.A., 1958 (distinction and honors); Princeton University, graduate study; and George Washington University, M.A., 1966.
Experience: 1960–61—Management intern, National Institutes of Health; 1961–62—Airman, USAF; 1962–63—Management analyst, National Institutes of Health; 1963–65—Assistant to the Assistant Secretary for Administration, Department of Health, Education, and Welfare; 1965–67—Executive officer, National Library of Medicine; 1967–70—Executive officer, National Institute of

Mental Health; 1970–73—Deputy Director, National Institute of Mental Health; 1973–74—Visiting academic, London School of Economics; and 1974– —Acting administrator, Alcohol, Drug Abuse, and Mental Health Administration.

Societies: Pi Sigma Alpha, American Society of Public Administration, and American Political Science Association.

Honors and fellowships: University of Michigan alumni honor award, Ethyl Kilham modern language scholarship, Kappa Sigma national scholarship leadership award, Oreon Scott prize, national Woodrow Wilson fellowship, and George Washington University scholarship.

BERTRAM S. BROWN, M.D.

Date and place of birth: Brooklyn, N.Y., January 28, 1931.

Marital status: Married 1952, four children.

Education: June 1952—B.A., Brooklyn College; June 1956—M.D., Cornell University Medical College; and June 1960—M.P.H., Harvard University School of Medicine.

Postgraduate training: July 1956 to June 1957—intern, Yale University School of Medicine, Department of Pediatrics; and July 1957 to June 1960—resident and teaching fellow (psychiatry) Harvard Medical School (Boston Psychopathic Hospital), Massachusetts Mental Health Center.

Certification: Diplomate, American Board of Psychiatry and Neurology, 1963.

Experience: July 1958 to November 1959—Senior psychiatrist, Division of Legal Medicine, Commonwealth of Massachusetts; Director of Psychiatry, Norfolk Prison Colony. April 1960 to present—U.S. Public Health Service, National Institute of Mental Health. April 1, 1960 to July 4, 1961—1. Staff psychiatrist, Mental Health Study Center. July 5, 1961 to October 14, 1963—2. Special assistant for program, extramural programs. October 15, 1963 to March 22, 1964—3. Special assistant for program, Office of the Director. March 23, 1964 to June 5, 1966—4. Chief, Community Mental Health Facilities branch. June 9, 1966 to December 31, 1966—5. Associate Director for Mental Health Service Programs. January 1, 1967 to June 2, 1970—6. Deputy Director, National Institute of Mental Health. June 3, 1970 to present—7. Director, National Institute of Mental Health. October 1961 to October 1962—Staff Director, President's Panel on Mental Retardation. (See: Report to the President, "A Proposed Program for National Action to Combat Mental Retardation," PPMR, GPO, Washington, D.C., October 1962.) December 1962 to July 1963—Deputy Special Assistant to the President for Mental Retardation, The White House. November 1970 to September 1972—Special Assistant to the Secretary of HEW for Drug Abuse Prevention. November 1971 to July 1973—Deputy Administrator for Mental Health, Health Services and Mental Health Administration, HEW.

Special missions: September 1972—Headed NIMH delegation to the Soviet Union. May 1973—Headed NIMH delegation to Japan for U.S.-Japan mental health mission.

Consultant (White House): June 1961 to Present—President's Committee on Employment of the Handicapped. July 1963 to July 1966—Office of the Special Assistant to the President for Mental Retardation. July 1966 to July 1967—President's Commission on the Administration of Law Enforcement and Justice. April 1968 to November 1969—President's Commission on the Causes and Prevention of Violence. January 1970 to June 1970—Executive Secretary, The President's Task Force on the Mentally Handicapped.

Consultant (partial listing): October 1959 to April 1960—Research Consultant, Cambridge Services for Retarded Children, Children's Bureau Demonstration Project, Cambridge Health Department, Massachusetts. 1960 to 1961—Outdoor Resources Recreation Review, Commission, Washington, D.C. 1962 to Present—Technical Advisory Board, Maurice Falk Medical Foundation, Pittsburgh, Pa. April 1969 to Present—Task Force to develop policy recommendations on health aspects of malnutrition, USPHS. June 1969 to Present—U.S. Committee on the International Congress on Social Welfare. 1970 to Present—Hogg Foundation National Advisory Council.

Academic teaching appointments: July 1958 to June 1960—Field work supervisor, Department of Social Relations, Harvard University. 1958 and 1959—Faculty, Boston University Institute on "Rehabilitation of the Emotionally Handicapped." January 1962 to 1972—Associate clinical professor of psychiatry, George Washington University Medical School. January 1971 to Present—Clinical professor of psychiatry and behavioral sciences, George Washington University Medical School. January 1965 to Present—Senior faculty, Washington School of Psychiatry.

Military service: U.S. Air Force, May 1957 to March 1960. First Lieutenant (Inactive Reserve).

Honors and awards: Phi Beta Kappa (Brooklyn College); Alpha Omega Alpha (Cornell); Delta Omega (Harvard); Commendation Medal, U.S. Public Health Service Commissioned Corps, January 1967; Arthur S. Flemming Award, February 1969; Maryland Mental Health Citizens Award, May 1969; Anchor Club Award, June 1972; and Meritorious Service Medal, U.S. Public Health Service, June 1973.

Professional societies: American Board of Psychiatry and Neurology (diplomate), American Psychiatric Association (fellow), American Public Health Association (fellow), American Orthopsychiatric Association (fellow), Council on National and International Affairs (fellow), American College of Psychiatrists (fellow), American Sociological Association, American Association on Mental Deficiency, and American Medical Association.

MORRIS EDWARD CHAFETZ, M.D.

Birthplace and date: Worcester, Mass., April 20, 1924.

Marital status: Married, three children.

Education: Tufts College, Somerville, Mass., B.S. 1944; Tufts Medical School, Boston, Mass., M.D. 1948; Intern, U.S. Marine Hospital, Detroit, Mich., 1948–49; and resident psychiatrist, State Hospital, Howard, R.I., 1949–51.

Board certification: Diplomate, American Board of Psychiatry and Neurology.

Professional training and appointments: 1951–1952—Fellow in neurophysiology, Instituto Nacional de Cardiologia, Mexico, DF. 1952—Psychiatrist, U.S. Coast Guard, Cape May, N.J. 1952–54—Clinical and research fellow in psychiatry, Massachusetts General Hospital. 1953–54—Research fellow in psychiatry, Harvard Medical School. 1954–57—Assistant in psychiatry, Harvard Medical School. 1954–55—Clinical assistant in psychiatry, Massachusetts General Hospital. 1955–57—Assistant in psychiatry, Massachusetts General Hospital. 1957–58—Assistant psychiatrist, Massachusetts General Hospital. 1957–61—Instructor in psychiatry, Harvard Medical School. 1957–68—Director, alcohol clinic, Massachusetts General Hospital. 1958–64—Associate psychiatrist, Massachusetts General Hospital. 1958–70—Consulting psychiatrist, Massachusets Eye and Ear Infirmary. 1959–64—Special consultant to National Institute of Mental Health. 1961–64—Clinical associate in psychiatry, Harvard Medical School. 1961–68—Director, acute psychiatric services, Massachusetts General Hospital. 1963–70—Research consultant, Memorial Hospital, North Conway, N.H. 1964–68—Assistant clinical professor in psychiatry, Harvard Medical School. 1964–70—Psychiatrist, Massachusetts General Hospital. 1968–70—Associate clinical professor of psychiatry, Harvard Medical School. 1968–70—Director, clinical psychiatric services, Massachusetts General Hospital. 1970–71—Acting director, Division of Alcohol Abuse and Alchoholism, National Institute of Mental Health. 1971—Director, National Institute on Alcohol Abuse and Alcoholism, National Institute of Mental Health (now (1973) Alcohol, Drug Abuse, and Mental Health Administration).

Memberships: American Psychiatric Association: Committee on Therapy, 1964; Task Force on Alcoholism and Drug Abuse, 1969–70; and chairman, Task Force on Alcoholism, 1970–72. American Orthopsychiatric Association. American Medical Association: Committee on Alcoholism and Drug Dependence, 1965–72. American Hospital Association: Advisory Committee on Mental Health Care Institutions and Service, 1968–70; and Advisory Committee on Hospital Care of the Alcoholic, 1969–70. American Association for the Advancement of Science. Governor's Advisory Council on Mental Health, Massachusetts, 1964–70. Group for the Advancement of Psychiatry: Mental Health Services Committee, 1963–. NIMH Ad Hoc Review Board on Research in Alcoholism, 1958–61. Subcommittee on Alcoholism, Massachusetts Mental Health Planning Project, 1963–. Secretary of Health, Education, and Welfare Planning Committee on alcoholism programs, 1963. Sigma XI. Consultant, Student Association for the Study of Hallucinogens, 1968–70. Advisory Committee on Alcoholism of the Attorney General's Office of Massachusetts, 1969–70. Corresponding Member of the Institute for Study and Prevention of Alcoholism in Zagreb, 1971–. Consultant, Pan American Health Organization, 1972–. Consultant, National Commission on Marihuana and Drug Abuse 1971–73.

Editorial appointments: Medical Insight, Editorial Advisory Board; Mental Health Digest, Editorial Advisory Board; Psychiatric Opinion, Editorial Board; Journal of Nervous and Mental Disease, Guest Editor; Evaluation, Editorial Review Board; and Labor-Management Alcoholism Newsletter, National Council on Alcoholism Editorial Advisory Board.

Honors and other special scientific recognition: Maudsley bequest lecturer, University of Edinburgh, Edinburgh, Scotland, 1969. Moses Greeley Parker lecturer, 1969. Louis and Amelia Block lecturer, Mount Zion Hospital and Medical Center, San Francisco, Calif., 1969. International Film and TV Festival of New York Gold Medal, 1972. Mount Airy Gold Medal Award, Denver, Colo., 1974.

ROBERT L. DUPONT, M.D.

Date of birth: March 25, 1936 (Toledo, Ohio).

Current full-time positions: Director, Special Action Office for Drug Abuse Prevention, Executive Office of the President, 726 Jackson Place NW., Washington, D.C. 20500, (202) 456-6620. Director, National Institute on Drug Abuse, Department of Health, Education, and Welfare, 5600 Fishers Lane, Rockville, Md. 20852, (301) 443-6565.

Education: June 1954—Graduated from East Denver High School; June 1958—B.A., Emory University, Atlanta, Ga.; and June 1963—M.D., Harvard Medical School, Boston, Mass.

Post-graduate training: 1963–64—Medical intern, Cleveland Metropolitan General Hospital, Western Reserve Medical School, Cleveland, Ohio. 1963–66—Psychiatric resident and teaching, fellow in psychiatry, Massachusetts Mental Health Center, Harvard Medical School, Boston, Mass. 1966–68—Clinical Associate, Laboratory of Clinical Sciences, National Institute of Mental Health, Bethesda, Md.

Brief chronology of employment: 1959, (2 months)—epidemiology trainee, California Department of Public Health, Berkeley, Calif. 1961, (3 months)—research assistant, tuberculosis laboratory, Communicable Disease Center, Atlanta, Ga. 1964–65—psychiatrist, Washington Hospital, Jamaica Plains, Mass. (part time position). 1965–66—senior psychiatrist, Massachusetts Department of Corrections, Norfolk Prison, Norfolk, Mass. (part time position). 1968–70—research psychiatrist and Acting Associate Director for Community Services, District of Columbia Department of Corrections, Washington, D.C. 1970–73—administrator, Narcotics Treatment Administration, Department of Human Resources, government of the District of Columbia, Washington, D.C. 1974, (2 months)—acting administrator, Alcohol, Drug Abuse, and Mental Health Administration, Department of Health, Education, and Welfare, Rockville, Md.

Consultantships and board memberships: 1967–68—consultant on research and development, District of Columbia Department of Corrections, Washington, D.C. 1968–71—consultant, Child Research Branch, National Institute of Mental Health, Bethesda, Md. 1971–72—consultant, American Bar Association, Special Committee on Crime Prevention and Control, Washington, D.C. 1971–72—member, The Armed Forces Epidemiological Board, Committee on Drug Abuse, Washington, D.C. 1971–73—consultant to the Food and Drug Administration, Bureau of Drugs, Rockville, Md. 1971–73—member, board of directors, Center for Correctional Justice, Washington, D.C. 1971–73—consultant to the Special Action Office for Drug Abuse Prevention, the White House, Washington, D.C. 1971–73—consultant, Veterans Administration, Washington, D.C. 1972–73—member, National Advisory Council on Drug Abuse Prevention, A Presidential Appointment, Washington, D.C. 1972–73—member, Drug Abuse Task Force, National Advisory Commission on Criminal Justice Standards and Goals, Department of Justice, Washington, D.C. 1972–Present—Washington Junior League Advisory Committee, Washington, D.C. 1972–Present—member, board of directors, Washington Society for the Performing Arts. 1974–Present—chairman, section on drug dependency, World Psychiatric Association.

Honors: 1971–72—Melvin C. Hazen award to the outstanding young man in the District of Columbia government (presented by the Downtown Jaycees). 1973—Meritorious service award, District of Columbia government.

Military service: 1966–68—Surgeon (Major), U.S. Public Health Service, National Institute of Mental Health, Bethesda, Md.

Societies: District of Columbia Medical Society, Washington Psychiatric Society, Washington Area Council on Alcoholism and Drug Abuse, American Psychiatric Association, American Correctional Association, National Council on Crime and Delinquency, Medical Corrective Association, American Academy of Psychiatry and Law, American Public Health Association, and Pan American Medical Association.

Faculty appointments: 1964–66—teaching fellow in psychiatry, Harvard Medical School. 1970–72 assistant clinical professor of psychiatry, George Washington University Medical School. 1972–Present—Associate clinical professor of psychiatry and behavioral sciences, George Washington Medical School.

Professional publications:

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INTRODUCTION OF WITNESSES

Mr. FLOOD. Now, whom do you have with you?

Mr. ISBISTER. I would like to introduce two of the three Institute Directors who are here at the moment, both well known to this committee, Dr. Bertram Brown, the Director of National Institute of Mental Health, and Dr. Morris Chafetz, Director of the National Institute on Alcohol Abuse and Alcoholism, and at my immediate left is the Executive Officer of the Alcohol, Drug Abuse and Mental Health Administration, Mr. Joseph Leone. Dr. Robert DuPont will be here shortly. He is the Director of the National Institute on Drug Abuse.

Mr. FLOOD. All right. You have a prepared statement. How do you want to handle that?

Mr. ISBISTER. I would like to go through, if I may, Mr. Chairman, reading most of the statement since we have attempted to describe our programs, or if it is your preference, we could submit it for the record.

GENERAL STATEMENT

Mr. FLOOD. Well, suppose we submit it for the record because in view of the number of institutes involved here, there will be a lot of questioning of your shops, I imagine. You have quite a collection.

All right; without objection, then, you will submit your prepared statement for the record.

[The statement follows:]

Mr. Chairman and members of the committee, it is a pleasure to appear before this committee today to discuss the programs of the Alcohol, Drug Abuse, and Mental Health Administration for the coming fiscal year. I have with me the Directors of the three Insitutes that comprise our Agency.

As the members of this committee are aware, the scope and magnitude of alcohol, drug abuse, and mental health problems in the Nation are enormous.

ALCOHOL ABUSE AND ALCOHOLISM

There are approximately 9 million alcoholic men and women in the country. Alcohol abuse and alcoholism not only cause immense suffering and destruction to individuals and families, and waste vast human potential—these problems also exert a great financial drain on the country, recently estimated in a comprehensive study at $25 billion.

DRUG ABUSE

Best recent estimates of the extent of other drug abuse problems in the United States include the finding that there were 725,000 active narcotics users in 1974. Other user statistics include 12.4 million for marihuana, and 6.8 million and 5.3 million respectively using stimulants and sedatives for nonmedical purposes. The highly dangerous practice of utilizing a mixture of drugs, including alcohol, is likewise extensive and growing. Beyond the countless personal tragedies these facts and figures signify, abuse of drugs other than alcohol adds $10 billion to the national economic loss.

MENTAL HEALTH

A further concern of immense dimensions to the Nation is the 1 in 10 of our citizens—or approximately 20 million Americans—who are afflicted by

emotional disturbances. The major mental illnesses continue to strike heavily throughout the population. In any given year, 15 percent of adults aged 18 to 74 may suffer significant symptoms of depression. And, more than 2 million Americans alive today will experience some degree of disruption in their lives as a result of schizophrenia.

Based on a study of the cost of mental illness in 1971, we estimate that this constellation of problems cost the Nation $37 billion last year. Of this amount, $15 billion—or 14 percent of all health-care expenditures in the Nation—went for direct care.

I am gratified to report to you today that we are making progress in our programs to deal with hits broad spectrum of human problems and their impact. We nevertheless have a long, long way to go.

For the sake of clarity and organization, I would like to briefly describe our programs and plans by Institute.

TREATMENT AND PREVENTION OF ALCOHOLISM

The highest priority of the National Institute on Alcohol Abuse and Alcoholism since it was established just over 4 years ago has been to make effective, quality treatment available. Significant progress has been made through direct funding of treatment programs and through formula grants to the States. Today, there are nearly 700 federally funded alcoholism service programs.

Early identification of trouble from one's use of alcohol is increasingly recognized as vitally important to an alcoholic person's chances of recovery. Because we know that alcoholism often can be detected at very early stages in the workplace, the NIAAA supports as a high priority, occupational alcoholism programs aimed at the development of service programs within the industrial environment.

Other special programs are aimed at alcohol problems found among certain segments of our society: for instance, women, alcoholic persons encountered in the criminal justice system, American Indians, and public inebriates. In toto, these targeted efforts will include continuation funding for an estimated 344 projects in the coming fiscal year.

Ongoing NIAAA-supported alcoholism treatment programs are currently being systematically monitored so that the long-range effectiveness of various treatment modalities can be reliably evaluated. Other Institute steps toward quality care have included development of a model benefits package which covers inpatient and outpatient alcoholism treatment under regular medical insurance, and the development of standards for treatment facilities through a contract with the Joint Commission on Accreditation of Hospitals.

We know that alcohol abuse and alcoholism will never be eliminated by treatment-oriented efforts alone. Accordingly, the Alcohol Institute places a strong second priority on prevention, particularly among youth.

One of the main thrusts of the prevention effort is to solicit the grass roots help of volunteer agencies, such as the Jaycees, Y.M.C.A., and several others. The NIAAA prevention division also is helping to develop curriculum guides and collateral material to be used in the country's school system to instill positive, healthy attitudes concerning the use or nonuse of alcoholic beverages. Altogether, NIAAA funds 48 prevention programs.

As reported by the Secretary in his second special report to the Congress on Alcohol and Health in June 1974, the status of knowledge concerning alcohol programs has advanced in many directions.

ALCOHOLISM RESEARCH

Much of the new evidence portrays the potential harm from heavy alcohol consumption in ever graver terms. For instance, the report points out that the excessive use of alcohol, especially when combined with tobacco, may be associated with certain cancers. For the moment, this remains a statistical, not a causal, link, but it requires urgent exploration. NIAAA-supported research has also demonstrated that heavy drinking during pregnancy can adversely affect the offspring of alcoholic mothers.

On the other hand, there is recent evidence that moderate drinkers have lower mortality rates from coronary heart disease than do abstainers or ex-drinkers, and that alcohol consumption is positively related to physical and psychological well-being in institutionalized elderly people. During the next year, we will follow these and many other leads which promise to expand our understanding of alcohol and its effects.

DRUG ABUSE TREATMENT

In response to other serious drug problems in the Nation, the National Institute on Drug Abuse is continuing a wide range of activities aimed at strengthening the national capability to treat drug abusers and to prevent further increases in their numbers. We are concerned about recent evidence of a national resurgence in heroin addiction and are watching indicators of this trend very closely.

In fiscal year 1976, the Institute will continue to support community drug abuse service programs at the current capacity level, which provides an ability to treat 95,000 drug abusers in NIDA-funded projects on any given day, and 161,000 persons annually. During the coming year, the States, assisted by statewide treatment service contracts and formula grants from NIDA, will increasingly assume administrative responsibility for these federally initiated service programs.

NIDA is particularly concerned that treatment projects operate with high standards of performance. As one measure for helping maintain a quality standard, ongoing NIDA-funded treatment service projects will continue to be monitored for treatment effectiveness by Federal staff. State and local programs will be assisted as well by the national data collection and retrieval system established by the Institute to make available programmatic, scientific, and technical information needed by managers of service and prevention activities.

To meet continuing manpower requirements, a coordinated national partnership program for career development of drug abuse treatment workers is being pursued. We will work with the single State drug abuse agencies to establish credentialing standards for drug abuse workers, including recommending minimum education and training requirements for each level and type of credential. As a major share of the responsibility to insure the availability of qualified manpower in treatment programs is transferred to the State, the National Institute on Drug Abuse will concentrate its strength on such activities as designating training models for sparsely populated States, and offering specialized education courses through its national training center.

The final solution to many of our drug abuse problems, of course, depends ultimately upon prevention, and the development of new knowledge concerning the causes, treatment, and control of drug using behavior. Required research progress is being made in many directions. New treatment techniques, such as use of the narcotic antagonist "naltrexone," are under the most rapid scientific development possible consistent with human safety.

DRUG ABUSE RESEARCH

Several NIDA grantees have made significant progress in establishing the chain of causality between the time a drug combines with its specific central nervous system receptor, and the resulting pharmacological effects in the organism. In the case of the opiates, this research seeks a better understanding of the mechanism responsible for the development of tolerance and dependence, which in turn will lead to improved methods of prevention, early intervention, and treatment.

Recent findings raise important questions concerning the possible effects of marihuana on the body's immune response system, cell metabolism, and male sex hormone levels. Accordingly, we are undertaking further marihuana studies to clarify these issues, which take on special importance because of the millions of people, young and old alike, who are using marihuana today.

At NIDA's Lexington, Ky., addiction research center—which in June will observe its 40th anniversary of significant contributions to understanding the addictive process—studies of the abuse potential of narcotic depressants, stimulants, and hallucinogens will continue in an attempt to identify addicting drugs early and, through appropriate control, limit their abuse.

NATIONAL INSTITUTE OF MENTAL HEALTH

Let me now turn to the programs of the National Institute of Mental Health, the "elder statesman" within the young Alcohol, Drug Abuse, and Mental Health Administration. Since its establishment in 1948, NIMH has been a stimulus for—and participant in—many of the dramatic changes in the national mental health scene.

Twenty years ago, the number of patients confined to State and county mental hospitals was at an all-time high of 559,000. From that point, a downward trend began. The advent of psychoactive drugs played a major part in turning the tide.

COMMUNITY MENTAL HEALTH CENTERS

Ten years ago, the community mental health centers program was established, and the shift toward shorter periods of hospitalization and community-based treatment began in earnest.

It is interesting to note that by the third anniversary of the centers program, the rate of decline in the number of patients hospitalized had accelerated to approximately 8 percent annually. By 1972, the rate was 12 percent. By last June, the number of patients in mental institutions had decreased to 216,000, a drop of 50 percent from 25 years earlier.

At the end of last fiscal year, there were 591 federally funded community mental health centers. When all funded centers are operational, services at the community level will be available to approximately 41 percent of the Nation's population.

To evaluate its research programs, NIMH has completed a detailed study of the results of investigations supported in the past 25 years. Recommendations by the study task force, which include outside experts and NIMH staff, call for an increased effort to compile more detailed information about the extent of mental illness and the results of treatment; further research to clarify the influences of heredity upon mental illness and on normal behavior; more information on preventive factors; and more sound information on how biological, psychlogical, and sociocultural factors interact in mental health and illness.

MENTAL HEALTH RESEARCH

We have already learned a great deal from our mental health research: We now know that information is transmitted through the brain and nervous system by the release of biochemicals called neurotransmitters, and that these neurotransmitters are important factors in mental illness * * * Research in psychopharmacology has resulted in drug treatment of schizophrenia and depression * * * Research has shown that there is a genetic component in schizophrenia and the affective disorders * * * Research has also found that conditions with hereditary factors need not be considered irreversbile, but that appropriate actions can prevent the manifestations of the condition.

The accomplishments I have mentioned are only a few among many advances against mental lilness. In the new fiscal year, NIMH will continue its quest to replace the mysteries of mental illness with needed knowledge through an intense research program within the resources available.

The decade that saw the dramatic turn-around in mental hospital versus com-

The decades that saw the dramatic turn-around in mental hospital versus coming numbers of mental health professionals entering the service delivery system began to have an effect. In 1948, this group numbered 15,000, today there are well over 100,000. NIMH had a major role in this dramatic increase of well-qualified personnel, as well as in improving the capabilities of educational institutions to offer superior training opportunities. It is now felt that training programs have been developed to the point that Federal subsidies are no longer required. Accordingly all training programs are proposed for phaseout.

SUMMARY

In conclusion, Mr. Chairman, the appropriation request for Alcohol, Drug Abuse, and Mental Health in 1976 is $653,627,000, a decrease of $163,305,000 below the fiscal year 1975 level. This overall decrease results from a reduction in research programs of $17,079,000; a reduction of $59,921,000 related to the phaseout of training programs; a reduction of $66,778,000 related to the decrease in Federal support for community mental health centers; a reduction of $25,857,000 in alcohol community programs; a reduction of $2,110,000 in program management funds; and a reduction in buildings and facilities of $7,522,000. These decreases are offset by an increase of $15,962,000 required to maintain treatment capacity for 95,000 drug abusers at any one time.

Mr. FLOOD. As you know, if you have any of your people with you here who wish to volunteer any information at any time or an-

swer any questions, they can speak right up. They don't have to wait to be called on. They are all pros, or you can call on them. But if they do speak, we would like a short biographical sketch of that witness at that point.

IMPACT OF BUDGET REDUCTION

Now, this budget request before us proposes a 20-percent reduction. What is the impact of this reduction on the activities of each of your institutes?

Mr. ISBISTER. The principal and largest items of reduction, Mr. Chairman, would be the training grant programs of the National Institute of Mental Health as well as the training programs of the other two institutes. We are estimating a reduction of $48.5 million in training in general mental health, $10.8 million in drug abuse, and $600,000 in alcoholism. This is consonant with the proposal that the special emphasis training programs be phased out. So this budget proposes no new training starts in fiscal year 1976.

The other two major components of the decrease are the service delivery programs of the Alcoholism Institute, where the recommendation is a reduction of $19½ million in project grants and contracts for the Alcoholism Institute and $6.4 million in the formula grant program to the States for undertaking alcoholism programs.

In addition, the budget represents a reduction of some $36 million in the staffing of community mental health centers and $28 million for construction of mental health centers consonant with the administration's proposal that we undertake no new starts in that program and merely pay for the remaining cost of the projects already started over an 8-year period.

Mr. FLOOD. How long have you been on board now in this job?

Mr. ISBISTER. I have been in this job since September. I returned to the country, as a matter of fact, in the latter part of August and was appointed as the Acting Administrator in the middle of September.

FUNDING NONCOMPETING COMMITMENTS

Mr. FLOOD. Are you going to be able to fund all the noncompeting commitments under this budget?

Mr. ISBISTER. We will not be able to fund all the noncompeting grants, Mr. Chairman, at the full levels.

Mr. FLOOD. How much money would be needed, then, in addition to what you are talking about, to pay for all the noncompeting grants?

Mr. ISBISTER. We would require for the training grant programs of the National Institute of Mental Health an additional $32.8 million, for the training grant programs of the National Institute on Drug Abuse, $3.9 million, and for the training grant programs of the Alcoholism Institute, $5.6 million. For the service delivery project grant and contract programs of the Alcholism Institute, $7 million, and for the research programs of the Alcoholism Institute, $786,000.

THIRD PARTY PAYMENTS

Mr. FLOOD. In your justification you state that in each one of your programs you will place a much greater reliance on income from the third party insurance payments. What hard data do you have in the

areas of mental health, alcoholism, drug abuse, to support the statements that the third parties will provide the necessary support to operate all of these programs?

Mr. ISBISTER. We have some evidence, Mr. Chairman, that we have been able to increase the amount of third party reimbursements obtained in all three of the programs. We have been working very hard in each of the three programs, working with the States on credentialing programs for paraprofessionals and on accreditation programs so that the service delivery projects which we support can be accredited for receiving third party reimbursements.

In the case of the Community Mental Health Centers program we are now obtaining, on the average, somewhat in excess of 20 percent of the Centers' income from third party reimbursements. In the case of the alcoholism treatment centers it is now about 11½ percent, and in the case of the drug abuse projects it is 2 percent or less.

As you know, there has been a tradition of placing various kinds of limitations in third party payment schemes in both the public and private sector for the provision of mental health, drug abuse and alcoholism services, and we have been working hard in all three of our institutes to overcome those barriers to reimbursement.

Mr. FLOOD. How much of the reduction are you expecting these third party payments to pick up?

Mr. ISBISTER. I think in the case of the Community Mental Health Centers one could hopefully estimate as much as 30 percent. We are now around 22 or 23 percent. In the case of the alcoholism service projects we have estimated that ultimately we could, in some of the projects, not all of them, obtain as much as 30 percent. Our experience has been that it is much more difficult to obtain third party reimbursement in the drug abuse projects.

Mr. FLOOD. What has been your experience to date regarding this payment from the third parties for all these services performed in these various programs?

Mr. ISBISTER. As I indicated, Mr. Chairman, it has varied by institute and by the type of program. If you take, for example, the Alcoholism Institute projects, it is very difficult to obtain reimbursements for some of those projects such as the special projects for provision of services to Indians, where the Indians are by right Federal beneficiaries. It has been easier to obtain reimbursements for projects under some of the occupational alcoholism programs, the alcoholism treatment centers, which we support, and so forth.

Mr. FLOOD. It has been easier?

Mr. ISBISTER. It has been easier; yes, sir.

Mr. FLOOD. I don't know how to argue about that if it has been easier. Why? What is the catch in this program vis-a-vis any one of the other two?

Mr. ISBISTER. I think it relates to the kinds of insurance which are available to the different populations being served and the extent to which we can obtain medicaid reimbursements that relate to specific populations. In the case of the occupational alcoholism programs, for example, all the people are employed and most firms, working with the unions, provide some form of health insurance. Dr. Chafetz and his staff have been working hard to develop a model benefits package so that private insurers will provide a full range of benefits for alcoholism services.

Mr. FLOOD. Well, it is my understanding that there was a recent ruling from the Office of the Secretary relating to this reimbursement to the community mental health centers from programs like the social services program, and that this ruling would nullify all your efforts to recover fees from these third parties. Can you tell us the details of any such ruling by the Secretary's office and how that is going to impact on the financial stability of the entire community mental health center program?

Mr. ISBISTER. The specific issue and tentative decision to which you refer are under titles 4(a) and 6.

Mr. FLOOD. We touched on those with Dr. Cooper the other day, but would like to hear from you, also.

Mr. ISBISTER. The issue there is whether or not in determining the amount of the reimbursement under titles 4(a) and 6 of the amount of the Federal grant-in-aid for a given project, in our case the community mental health grant-in-aid, should be deducted.

The second question is, should the amount of non-Federal grants also be deducted?

Mr. FLOOD. Under the ruling by the Secretary's Office now?

Mr. ISBISTER. Under the ruling for titles 4(a) and 6, both the amount of the Federal grant-in-aid for the community health center and the amount the States and localities have to come up with for the match is reduced before the reimbursement is made for the titles 4(a) and 6.

The Secretary, as Dr. Cooper indicated when we were here a week or so ago, currently has the issue again before him in connection with the establishment of the reimbursement policies for title 20, which is going to be replacing titles 4(a) and 6, and he has not made a final decision yet.

Mr. MILLER. These are contained in the regulations that are going out for comment on title 20, which goes into effect in October, Mr. Chairman. It is less restrictive. Mr. Isbister indicated that there were two areas where the Federal contribution had to be deducted. Now, I believe that the title 20 regulations are saying that the States cannot use the same money to match two programs, but now wherever there is an increasing participation by the State required in the Federal program, which is true of community mental health centers, the program is available for title 20 funds.

Mr. FLOOD. Do you have any estimates at all of how much revenue is going to be lost by the community mental health centers as a result of the ruling?

Mr. ISBISTER. We have general information that I don't have right with me, Mr. Chairman. I can present it for the record. It varies substantially from State to State. Some States, particularly Kentucky, have been very aggressive in obtaining the titles 4(a) and 6 funds for use in support of community mental health centers. The same thing is true in Florida, and in those States it would have a considerable impact.

In many States there has not been substantial use of those funds for support of community mental health activity.

Mr. FLOOD. This we want to know for obvious reasons, so have the record show it.

Mr. ISBISTER. Yes, sir.

[The information follows:]

LOST CMHC REVENUE FROM TITLE 20

Under the proposed regulations pursuant to title 20, there is a provision (section 228.53(b)(2)) enabling the federally funded centers to receive reimbursement for appropriate services to eligible recipients. If allowable costs are reduced by the amount of the Federal staffing grant, however, which currently averages 30 percent of CMHC income, allowable costs will be at the rate of 70 cents on each dollar of service cost. It is not possible even to estimate at this point the amount of dollar loss to centers under these regulations. It is extremely difficult to predict a gross volume of services which might be eligible for title 20 reimbursement, given the range of variables under the new legislation, and in the light of experience under titles IV(A) and VI. With regard to the latter, Federal reporting requirements have only recently included a special line item for social service income and costs, and reliable data are in the process of being developed.

CMHC CONSTRUCTION GRANTS

Mr. FLOOD. In your justification you say there are 626 community mental health centers funded, but only 543 of these centers are operational. When do you expect the remaining 83 centers to be operational?

Mr. ISBISTER. The difference is represented exclusively, Mr. Chairman, by centers which have received construction grants, so that as they plan and complete the architectural drawings for and construct their facilities, they will then become operational. The leadtime between funding and operation is much greater for the construction grant programs than the staffing grants.

Mr. FLOOD. Do you need any law; do you need any authorizing legislation in order to award the new staffing grants to the 83 centers that are not operational? What is the problem, lack of funds? Which is it?

Mr. ISBISTER. No; when we award a construction grant, Mr. Chairman, it is with the firm understanding that there is no obligation for staffing grants to come forward after the building is constructed.

Mr. FLOOD. What is the problem? It's not law? It's not money?

Mr. ISBISTER. The problem is that it just takes a long time to get the building designed and built, and these are grants that we have awarded within the last year or two and the leadtime often is 2 to 3 years to get the building constructed.

Mr. FLOOD. That is the problem?

Mr. ISBISTER. Yes. But to respond to your other question about the law, the existing community mental health centers legislation has expired, and it is a matter that is currently under consideration by the substantive committees involved.

Mr. MILLER. I don't want to mislead you, Mr. Chairman. For several years we have enunciated a policy in the budget that we do not want to provide Federal support for new community mental health centers.

Mr. FLOOD. How do you finance the operating budget if it is a question of funds? You say it is not funds; it is not law; then is it a question of timing?

Mr. ISBISTER. For a center which receives a construction grant Mr. Chairman, they have to provide us with assurance that they will be

able to generate sufficient local and other resources to operate the facility once it is constructed. That is part of the grant approval process with the construction grants.

Mr. FLOOD. You have no problem, then, as far as you are concerned, in operating your budget in that kind of answer. You have no problem on your budget, is that it, for the 83 not yet operational?

Mr. ISBISTER. That is correct, sir.

MENTAL HEALTH TRAINING

Mr. FLOOD. Now, you show a very substantial reduction in the mental health training. As a matter of fact, your budget proposes a 56 percent reduction for mental health training. What does that mean? Is the market saturated now with mental health workers; is that it?

Mr. ISBISTER. No, we don't believe that at all, Mr. Chairman. There is a continuing need for mental health workers and for workers in the four professional areas that we support, psychiatry, social work, clinical psychology, and psychiatric nursing, as well as the paraprofessional areas.

The question is not if we need additional manpower but rather what should be the appropriate Federal role in financing these training programs.

Mr. FLOOD. Are there a sufficient number of mental health workers available now to meet the current demands for all these mental health services?

Mr. ISBISTER. No; and we will have to generate additional manpower for the future, Mr. Chairman. The decision reflected in this budget is that these special emphasis programs which were designed 10 and 15 years ago to provide a special spurt for the production of personnel in these areas are no longer needed. The manpower is still needed but the proposal here is that it should no longer be a special Federal responsibility to generate this manpower.

PROJECTION OF MANPOWER NEEDS

Mr. FLOOD. All right. Do you have any estimate of the number of mental health workers you are going to need, say, in the next 5 years if there is a national health insurance act that is passed by the Congress?

Mr. ISBISTER. We have done some estimates. If you took a projection to 1981 and assumed that national health insurance would increase the utilization rate to 3½ percent, then we would have to generate and produce additional manpower in all four of the categories. We estimate that we would need about 40,000 psychiatrists, about 31,000 psychologists, 31,000 psychiatric social workers, and 56,000 psychiatric nurses.

ALTERNATIVE TRAINING SUPPORT

Mr. FLOOD. Suppose we approve this budget you are presenting, with this very large reduction in training funds. How would these various training programs support themselves?

Mr. ISBISTER. The first form of support could come from the individuals being trained themselves, recognizing that ultimately there is a certain economic benefit derived from the education.

There are loan programs which are available, and we would hope that the States and the localities would pick up part of the cost.

Mr. FLOOD. You would hope?

Mr. ISBISTER. But the principal source would have to be the financial resources of the students, themselves, and their ability to obtain loans.

Mr. FLOOD. So if a national health insurance act is passed over the next 3 to 5 years, what we have to go on, is what you just said; is that it? That is not a very stable foundation, is it?

Mr. ISBISTER. That is the proposal, Mr. Chairman; yes, sir.

Mr. FLOOD. That is all you have to say right now?

Mr. ISBISTER. Those are the ways in which the training would have to be supported.

Mr. FLOOD. Not many ways, are there? These are not rhetorical questions.

Mr. ISBISTER. I think that through these special emphasis programs we have, over a period of a number of years, increased the manpower available. We have built training capacities and institutional capacities for providing training, and we believe that many of these programs can continue in the future without special Federal support.

STATE INSTITUTIONS AND CMHCs

Mr. FLOOD. You must have your fingers crossed.

In your opening statement you said the number of patients now in the mental institutes has decreased by 50 percent in the past 25 years. Is it going to be possible to further reduce that number? If so, what steps are you going to take to do that?

Mr. ISBISTER. I think whereas the rate of decrease of patients in State and county mental hospitals has accelerated for a number of years, we are now reaching the point where the curve is beginning to level off at around 200,000 resident patients.

Perhaps Dr. Brown would like to comment on that question, Mr. Chairman.

Dr. BROWN. The question is what will happen with this State hospital population, Mr. Chairman?

Mr. FLOOD. That is rephrasing it: all right.

Dr. BROWN. It depends on what happens with the rest of the service system. We have had great success in terms of decreasing the resident population from 570,000 down to almost 200,000. We had a more dramatic turning point that is not as well known. While this decrease was occurring in the resident population, the admission rate was going up. This indicates that the patients were being released more quickly. The patients have been picked up by the community care system; as you know, more people are being treated in the community. The State hospitals will probably become special treatment centers, taking care of difficult or unusual cases. It would be my hope that it will go down another 50 percent.

NEW RESEARCH PROJECTS

Mr. FLOOD. How about the new research projects? How many new research projects will NIMH be able to support with the President's budget for 1976? Is this going to be a repeat of what Dr. Egeberg told us last year when he said he just couldn't explain why the NIMH was given no research money? He threw up his hands. Where are you?

Mr. ISBISTER. We would be able to support 38 new small-grant projects in fiscal year 1976, Mr. Chairman.

Mr. FLOOD. Yes, small indeed.

Mr. ISBISTER. Yes, sir.

Mr. FLOOD. Small ones; is that it?

Mr. ISBISTER. Small grants; yes, sir. We have a special program, Mr. Chairman, for providing research grants up to $6,000 principally to young investigators who are just beginning their research careers. Under this budget we would be able to support 38 such awards.

Mr. FLOOD. Do you have any scientific areas that are really promising now that you are not going to be able to fund at all?

Mr. ISBISTER. We have a number of promising areas and things that have occurred in the last 2 or 3 years. I think perhaps I might best throw that question to the three Institute directors who are more directly responsible for the administration of our scientific activities and ask if they might each respond to that question.

Mr. FLOOD. Any volunteers?

Dr. BROWN. We have many promising areas, perhaps the most impressive of which is depressive——

Mr. FLOOD. That you are not going to be able to fund?

Dr. BROWN. We have at least a half dozen areas on the verge of delivering new knowledge that we would be unable to fund. I will be glad to document it for the record or give a speech.

Mr. FLOOD. Let's have both.

Dr. BROWN. For example, we have made dramatic advances in our treatment of depression, enough so I can say I would be happier to be depressed now than 20 years ago. We finally have some hot research leads in the biology of schizophrenia. We have exciting developments in the treatment of children's reading disabilities.

We also had a major breakthrough this past year which our scientists tell us may be the most significant finding in the last 2 years. It is a way, by looking at how sugar is metabolizing in the brain, of finding out how the nerve track goes in local places by specific traction. In order to do it the old way, you needed a million electrodes sitting in the brain. Now we will be able to do it by biochemical means, and this is extraordinarily promising in our search for how the brain operates.

We will be able to pursue that only in a modest way without new research grants funds.

Mr. FLOOD. So you have five or six projects, in your opinion, now, important projects, about to break, and you have been talking about them and nothing is going to happen to them because of no funding?

Dr. BROWN. Areas. They are not just projects, but entire research areas.

Mr. FLOOD. Is that right?

Dr. BROWN. That is it.

Mr. FLOOD. Well, all right. An interesting question for you is a comparison now of the research budget at NIMH and the categorical institutes, a whole flock of them, the National Institute of Health, say, over the last 5 years. We have the impression from the NIMH research budget that you have held steady and it has been held steady or decreased while that many of the NIH institutes have increased very sharply. Is that right?

Dr. BROWN. That is correct, Mr. Chairman.

DEFINING MENTAL HEALTH PRIORITIES

Mr. FLOOD. Well, that is quite a situation. What have you done to review the new research efforts? How do you define a priority at your shop?

Dr. BROWN. For the past 2 years, we have had a research task force to look at the billion dollars we have spent over the last 25 years. Two or three hundred outstanding Federal and non-Federal people participated. We examined the priority question and determined how you define a priority.

One is relevance to your mission. That is, is it psychiatric depression, mental illness; how relevant is it to the charge of the institute?

Another is whether the state of the art or science is ready to deliver.

The third is neglect, if it has been an area where nothing has been done and where we should try. Examples of this would have been mental retardation 15 years ago, or aging today.

Lastly, we look at the social importance. If you have an extensive problem such as depression is today, one might define a priority by getting at that socially important issue.

So you have the mission, the state of the art, the social importance of the issue, and whether it has been neglected. That is how we define a priority.

MENTAL HEALTH MANPOWER TRAINING

Mr. FLOOD. Does the President's 1976 budget allow any funds for these new mental health training projects?

Dr. BROWN. It is quite equitable in allowing no new funds for any areas.

Mr. FLOOD. Isn't that a contradiction in terms?

Dr. BROWN. No; if it allowed for one, one might say one of the four priority criteria were chosen above others.

Mr. FLOOD. You are going to balance equities again? Well, what problems have you and your staff run into in the review and management of the mental health manpower training programs during the current fiscal year? Do you anticipate running into the same kind of problems in 1976?

Dr. BROWN. The problems have been many, with red lights, green lights, and yellow lights snapping on and off; whether or not there would be a total phaseout or continuation; what funding would be available by Congress, by impoundment, rescissions, and the like. It has been an administrative nightmare, Mr. Chairman.

Mr. FLOOD. I am sure it has. It has been a nightmare for this subcommittee, too, for the same reasons you are saying. What about 1976? Do nightmares go by degrees, too?

Dr. BROWN. We are hoping that it will just improve from a nightmare to a bad dream.

MANPOWER NEEDS

Mr. FLOOD. Let me ask you this: Do we have enough psychiatrists now, and just to keep the status quo, how many more are we going to need, say, in the next 5 years?

Dr. BROWN. We took the most conservative set of estimates, assuming a moderate increase in demand related to the passage of National Health Insurance, and we are going to be short 9,000 psychiartists 5

years from now. We are going to be short 8,500 psychologists, 7,000 psychiatric social workers, and 12,000 psychiatric nurses. In other words, 5 years from now, we will have fallen behind.

Mr. FLOOD. How did you know I was going to ask you that?

Dr. BROWN. It was the same card Mr. Isbister got out.

UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

Mr. FLOOD. Last year, we were told that in 1975 a major effort would be made to support the implementation in the various States of the Uniform Alcoholism and Intoxication Treatment Act. That is the title of the act. How many States have adopted this model act?

Mr. ISBISTER. I would like to turn to Dr. Chafetz and give him a chance to participate.

Dr. CHAFETZ. Mr. Chairman, 21 States have adopted that model act. However, only 15 have implemented the act and the others have delayed the starting date for the switch from criminalization to a health model for alcoholic people.

Mr. FLOOD. When do you expect other States to do this?

Dr. CHAFETZ. Well, sir, we are hopeful that through other resources such as the formula grant activities, they will be able to develop their capability of moving sick people out of jails and into the health system.

Mr. FLOOD. Are there funds in this budget request to do this?

Dr. CHAFETZ. The budget request would provide no opportunities to implement the uniform act in additional States in the fiscal year 1976 budget.

Mr. ISBISTER. Except through the formula grant program for which we are requesting——

Mr. FLOOD. There is no budget request to do what I am talking about?

Mr. ISBISTER. Not specifically.

Mr. FLOOD. The answer is no; isn't it?

Mr. ISBISTER. No, sir.

INDUSTRIAL ALCOHOLISM PROGRAMS

Mr. FLOOD. No sir, well, all right.

In the hearings last year we were told the Alcoholism Institute was organizing and establishing alcohol treatment programs in private industry; remember? Well, how is that program progressing? By the way, are you able to solicit these third party payments for that treatment?

Dr. CHAFETZ. The third party payment, as Mr. Isbister correctly pointed out, has been around 11 percent as a totality for the alcohol treatment centers we are supporting. However, an interesting analysis of that data shows, as seems to be true in all of life, the haves tend to get and the have-nots do not. In other words, those early in their alcoholism and employed tend to get third party payments, but if you look at the disadvantaged groups, they get less than 2 percent reimbursement through third party payment.

Mr. FLOOD. That was the second part of the question.

Dr. CHAFETZ. The first part of the question concerned the occupational alcoholism programs. That continues to go gratifyingly well, Mr. Chairman. A number of industries are adopting this program because they have seen the cost benefit analysis. As you remember, through grants-in-aid moneys we hired two occupational alcoholism specialists for each State and had an extensive training program for them. Now that our 2-year support has terminated, most of the States are beginning, through their limited resources, to fund these specialists.

MODEL INSURANCE BENEFITS PACKAGE FOR ALCOHOLISM

Mr. FLOOD. Well, again, in the opening statement you talked about the Alcoholism Institute developing a model, benefits package, I think, was the phrase, which covers the inpatient and outpatient alcoholic treatment under regular medical insurance.

How many of the insurance companies have adopted the model?

Dr. CHAFETZ. As you can understand, Mr. Chairman, the whole issue of alcoholism as an illness has been something this Nation has avoided for most of its existence until the Congress created the Institute some 4 years ago. We have worked diligently, and I think with great promise, to change the system of third-party payments away from conventional systems because we found from our evaluation system that using credentialed individuals, and conventional care, produced a situation where they were highly costly and low in effectiveness.

So we decided that in order to buy into the third-party payment system, we had to come up with methods of certification and accreditation of caretakers and the places delivering care that would more nearly reflect the needs of the alcoholic.

Mr. FLOOD. I couldn't say that better myself. How many insurance companies have adopted the model?

Dr. CHAFETZ. In the neighboring State of Maryland 2 weeks ago, seven companies adopted the model, and these are the first in the country.

Mr. FLOOD. Seven?

Dr. CHAFETZ. Yes, sir.

Mr. FLOOD. Well, do you expect all of the major companies to adopt this by the end of the fiscal year 1976?

Dr. CHAFETZ. I think that would be too hopeful, but I would say that our 1975 funds have allowed us to reach, in the occupational program, better than 12,000 beneficiaries. With the new budget unfortunately the number will have to be reduced——

ADOPTION OF THE MODEL INSURANCE BENEFITS PACKAGE

Mr. FLOOD. How do you get the insurance companies to adopt this model benefit package.

Dr. CHAFETZ. Well, sir, I think it comes out in the same kind of thing that Liza Doolittle said: "Words, words, words; don't tell me words; show me."

Mr. FLOOD. She was good, too, but now you tell me.

Dr. CHAFETZ. A number of our people, both staff and through contracts have been going around to show the companies the cost-benefit analysis of instituting these programs and giving them technical assistance in setting them up.

INDIAN ALCOHOLISM PROJECTS

Mr. FLOOD. In your justification you state that the Alcoholism Institute—I think both of you touched on this—is committed to supporting treatment programs for the American Indians.

Dr. CHAFETZ. Yes, sir.

Mr. FLOOD. And you made quite a thing of that. How do you reconcile this commitment with the fact that you are proposing a 70-percent reduction in the funds for the Indian project? Houdini wasn't an Indian, but how do you do that, put those two things together?

Dr. CHAFETZ. In fiscal 1975 we will have active an estimated 168 Indian alcoholism treatment programs for about $16.9 million and in fiscal year 1976, we will have approximately 70 active grants for a total of $7.2 million.

The reason for that, Mr. Chairman, is that many of these programs will have reached the end of their third year of committed Federal support in 1976, and while there has been some question about it, the feeling has been that the Alcoholism Institute endeavors have been seed-money endeavors, and it is hoped they will use other resources to maintain this important endeavor.

Mr. FLOOD. They; who are they?

Dr. CHAFETZ. The Indian people.

Mr. FLOOD. You are committed to supporting these programs for the Indians. It is one of the greatest programs we have had. This is one of the greatest things that happened since they put sliced bread in packages, so you are going to reduce it 70 percent; is that it?

Dr. CHAFETZ. I am afraid that is accurate, sir.

Mr. MILLER. Mr. Chairman, you are raising the issue that goes throughout the budget.

Mr. FLOOD. I am talking about the Indians now.

Mr. MILLER. I am referring to that, too, and a number of the alcoholism and other projects in this budget and other budgets. Are they service projects that the Federal Government should support in perpetuity, or do they have a terminal date?

Mr. FLOOD. I am asking you.

Mr. MILLER. We say they are time-phased projects that eventually, if they are going to be continued in the community, have got to be picked up by the community, and the Federal Government is not committed to continue them as service projects forever. That is a major issue that this budget presents.

Mr. FLOOD. Period.

Mr. MILLER. Period. Yes.

ALCOHOL PROJECTS FOR LOW-INCOME FAMILIES

Mr. FLOOD. All right. You are also proposing a 90-percent reduction in the alcoholism projects for low-income families. Why such a reduction as that? Has this program that you presented so eloquently and dramatically, proven to be unsuccessful?

Dr. CHAFETZ. No; on the contrary, Mr. Chairman, it has been an important advocacy and community resource development among the poverty groups. However, I would like to remind the chairman that one of the earliest endeavors that the Congress gave the National Institute—as a matter of fact, it antedated the creation of the Insitute through the OEO programs—was the development of a poverty-oriented alcoholism endeavor. Many of these projects will have reached, as Mr. Miller pointed out, the end of their 3-year Federal commitment in 1976, so they must garner their own support from the communities.

Mr. FLOOD. In other words, Pontius Pilate was an amateur, right? Well, is there any other source of support for this?

Dr. CHAFETZ. We feel, Mr. Chairman, that with the advent and hopeful rapid passage of a national health insurance and with some of the other preparations we have provided to the country and communities at large, the opportunities for their having support would be enhanced.

ALCOHOLISM FORMULA GRANTS

Mr. FLOOD. You have this alcoholism formula grants to States. What percentage is used in the treatment services?

Dr. CHAFETZ. In the treatment services aspects coming from the formula grants, 67 percent of the moneys are spent for direct services on behalf of people. One of the more gratifying findings of this evaluation, Mr. Chairman, is while the law allows them to charge off up to 10 percent for administrative cost, our figures show that as a totality the States are only using 6.5 percent for administrative cost and are heavily engaged in providing services for people.

REDUCTIONS IN ALCOHOLISM FORMULA GRANTS

Mr. FLOOD. If such a very high percentage of these funds is actually going into providing treatment, as you say, and it is, then why in the world are you cutting the funds $6 million? In other words, the best thing to do around here is not be good; is that it; or what? What is the answer? Six million dollar cut. After all you said now, it is cut $6 million.

Dr. CHAFETZ. Mr. Chairman, I think you are familiar enough with my commitment to the necessity of this Nation to face up to the devastating and destructive aspects of alcoholism which visit us, but you and I also understand the realities of the economic squeeze that is going on as a totality for the country.

Mr. FLOOD. Well, do you have evidence to support your assumption that the States are going to absorb the cutback in the formula grants, both the cutback in the formula grants and the cutback in the project grants?

Dr. CHAFETZ. We have only tentative evidence about that. One of the evidences that would support that is a number of the States recognizing finally the need to deal with alcoholism programs once the State formula grants were provided through the alcoholism act, have added from their resources, moneys to implement the formula grant activities, and it is our hope that as our commitment is reduced, theirs will go up.

ALCOHOLISM AND YOUTH

Mr. FLOOD. Is alcohol abuse among our Nation's youth increasing?

Dr. CHAFETZ. We have just completed the largest probability sample ever done to my knowledge in this area. Just to give you an example, Dan Yankelovich, when he does a survey for Time magazine, uses 886; Mr. Gallup and Harris use 1,500. Our study involved a sample population of 15,000 young people between the ages of 12 and 17, and our study reflects the drinking behavior of 89 percent of the sample population in that age group; and we find the following: That young people have taken to alcohol as a drug of choice with almost universal appeal, but what is troublesome to us is that apparently 1.13 million of the young people between the ages of 12 and 17 are using alcohol in a way we consider a serious abuse problem. For example, they overdose with a drug—alcohol being a drug—more than once a week.

Mr. FLOOD. Alcohol is a drug?

Dr. CHAFETZ. Yes, sir; even the liquor industry has accepted that reality.

PREVENTION OF ALCOHOLISM

Mr. FLOOD. Does the Institute of Drug Abuse and Alcoholism support prevention programs in the Nation's schools?

Dr. CHAFETZ. The Institute from the first day of its organization created a division of prevention, which is heavily engaged at many levels in providing prevention programs through the schools and other mechanisms to try to deal with these problems.

Mr. FLOOD. How much do you spend on the drug prevention programs in the schools?

Dr. CHAFETZ. I would venture to guess—it is not as easy, Mr. Chairman, to reflect it as directly into the school because——

Mr. FLOOD. How much?

Dr. CHAFETZ. I would venture to guess close to $7 million.

Mr. FLOOD. Are you going to be doing any more in the schools with the problem of drug abuse and alcoholism?

Dr. CHAFETZ. As far as I am concerned, historically no social or health condition of mankind has ever been brought under control by just treating the casualties alone, even though that is a necessary effort. You bring things under control by moving into the prevention area.

Mr. FLOOD. Should you be doing more?

Dr. CHAFETZ. Very definitely, sir.

INCREASE IN HEROIN USE

Mr. FLOOD. Last year, Dr. Egeberg told us the rate of increase in the use of heroin was declining; is that true?

Mr. ISBISTER. I think we will shift down one more position here, and I would like to introduce Dr. DuPont, the Director of National Institute on Drug Abuse, and ask him to respond to that question, Mr. Chairman.

Dr. DUPONT. We had a declining heroin problem for about 18 months to 2 years in this country, particularly in the eastern part of the country. That declining trend has now reversed, and we see an increasing trend throughout the country. So the good news of last year——

Mr. FLOOD. Has it accelerated in the eastern part as well?

Dr. DUPONT. Yes, sir; all parts of the country are reporting increases in heroin use.

REDUCTION IN DRUG ABUSE BUDGET

Mr. FLOOD. With this apparent increase—not apparent; you declare there is now an increase in drug abuse—can we afford under those circumstances to cut back in the drug addiction, drug abuse training program? You know, this budget calls for a 75-percent reduction in drug abuse training. What about that?

Dr. DUPONT. I think that that decrease may present problems.

Mr. FLOOD. No fooling.

Dr. DUPONT. The reason for that decrease reflects the basic argument——

Mr. FLOOD. That is the most careful understatement of the morning.

Dr. DUPONT. I am just warming up, Mr. Chairman.

Mr. FLOOD. All right; get hot, mister; get hot.

Dr. DUPONT. If I may, I would like to point out in a somewhat broader perspective, that although the drug abuse budget appears to show an increase in total dollars, in fact it reflects an actual decrease in program level. This is because $17 million of fiscal year 1975 continuation costs were funded from a previous year's appropriation. The fiscal year 1976 budget provides funds for these commitments. It would be more accurate, therefore, to say that the drug abuse budget declines from an equivalent $237 million in 1975 to $222 million in 1976.

The sharpest decline is in the training areas, as you quite readily point out. The problem we have is within constricted resources where to put our primary emphasis, and, frankly, we have made our top priority our service and research programs with training being our secondary priority. This ranking was established on the basis of consideration of the importance of the Federal role in these areas. In none of these areas can we say, nor does the budget ever say, that we are meeting the total nationwide drug abuse needs.

EFFECTS OF MARIHUANA

Mr. FLOOD. In your statement you also say that marihuana may affect the body's immune response system. What do we know about that issue at this time?

Mr. ISBISTER. Again, I will ask Dr. DuPont to respond to that.

Dr. DUPONT. Mr. Chairman, we know that the white cells from marihuana smokers appear to behave differently from the white cells of people who have not smoked marihuana. We do not have any clinical evidence that people who smoke marihuana have reduced immune capability, although within the last 2 years, there is increasing evidence that marihuana does influence——

Mr. FLOOD. I want you to develop the answer to that question at some length. Will you?

Dr. DUPONT. Yes, sir. I will be happy to. I think the main point, if I might take a moment, is that a few years ago our marihuana research was exceedingly primitive. We did establish that certain of the deleterious effects previously attributed to marihuana smoking did not

have any basis in scientific fact. Unfortunately, many people in the general population concluded from this that marihuana was a safe substance.

As we continue our research in marihuana, we are identifying heretofore unknown problems, including the one you have singled out. However, that is only one of a number of areas where there are problems emerging.

Mr. FLOOD. I want you to develop that one.

[The information follows:]

RECENT RESEARCH FINDINGS ON MARIHUANA AND WHITE BLOOD CELLS

In recent months, several journals have reported conflicting results in studies of the effect of marihuana on the ability of white blood cells to maintain immunity to disease. One such report chronicled an experiment which contrasted the immune response in cells taken from 51 chronic marihuana users to the response in cells from 81 controls who had not used the drug. This was a test-tube experiment, and it showed a statistically significant impairment among the marihuana users which was very similar to the condition found in patients with known impairment of cellular immunity due to other causes.

However, these findings have been contradicted by at least two other studies. One involved the skin testing of 22 chronic marihuana users with a foreign antigen; this failed to find any evidence of impairment in cell immune response. The second was an attempt to confirm the findings of the aforementioned test-tube experiment. This study also found an essentially normal immune response in the cells of healthy, long-term marihuana smokers. These test differences cannot be explained at present, but problems of patient selection and differing times of last smoke before the blood sample was taken may have influenced the results.

Some scientists also point out that, while this possible impairment in the immune response might represent a potential hazard to normal users, it could suggest a potential therapeutic application of cannabis as an immunosuppressant and/or antitumor agent. According to reports based on animal studies, marihuana has shown both types of activity. However, the evidence at this time is equivocal and the clinical implications are unknown. Further work in this area is being encouraged by NIDA. We have several new studies just starting to follow up the immunological and cellular consequences of these early, conflicting findings.

DEFINING A MODERATE DRINKER

Mr. FLOOD. In your opening statement you also said there is recent evidence that moderate drinkers have a lower mortality rate from heart disease than do total abstainers or exdrinkers.

What in the world is a moderate drinker?

Mr. ISBISTER. The statement I prepared, Mr. Chairman, draws to the——

Mr. FLOOD. What is a moderate drinker?

Dr. CHAFETZ. Mr. Chairman, just to reassure the committee, in the report——

Mr. FLOOD. You are going to get a lot of attention now. What is the moderate drinker?

Dr. CHAFETZ. That is why I don't want to miss the opportunity, sir.

In the report that the Secretary of HEW made to Congress on alcohol and health, new knowledge in the field we reported that the level of moderate drinking, the upper limit I might add of safe drinking consisted of one and a half ounces of absolute alcohol per day, which one can achieve by consuming three ounces of whiskey well diluted or four beers, or half a bottle of wine.

I might add, if we may, that Mr. Harry Reasoner on one of his television reports said this was the first Federal report that relieved depression from one of his friends until he found I had said "or" instead of "and."

ALCOHOL ABUSE AND HEART DISEASE

Mr. FLOOD. You are talking about a lower mortality rate in heart disease so you have an audience. Is this conclusive evidence? This is very important, when you realize all of the publicity now that is being given lately to the poor condition of drinking water. You are going to get an audience.

Dr. CHAFETZ. I believe Mr. Herblock in the Washington Post illustrated that by showing W. C. Fields laughing, but I think that we must bear in mind something about these findings. These are generalized statistical findings that apply to large groups and have no relevance to individuals.

We carefully said——

Mr. FLOOD. You are talking about the mortality rate on the heart?

Dr. CHAFETZ. Yes, sir. We carefully said that these generalized statistical findings for large populations should not be extrapolated to individual decisionmaking because for some people even a small amount of alcohol can be deleterious for obvious reasons.

We are furthermore just starting an in-depth study of heart disease and alcohol which will be operated across the world through the World Health Organization. We want to follow this further.

Mr. ISBISTER. Dr. Chafetz made the introduction I wanted to and I would like to underscore that these findings presented here are provocative and possibly controversial. They are ones that are being followed up as leads by the research program.

ROLE OF VOLUNTEER ORGANIZATIONS

Mr. NATCHER. Gentlemen, I notice in your statement to the committee you have made the statement, and I quote:

> I am gratified to report to you today that we are making progress in our programs to deal with this broad spectrum of human problems and their impact. We, nevertheless, have a long, long way to go.

Gentlemen, I agree with that. I think you do. I don't think there is any question about it.

What cooperation are you receiving from the standpoint of your volunteer organizations at the grassroots? You point out the Jaycees and the YMCA are two at the grassroots. What about at the State level? Where are we from the standpoint of cooperation in the local communities and at the State level in regard to these programs that you have just testified about to the committee?

Mr. ISBISTER. Mr. Congressman, we have had active programs in promoting the use of volunteers in all three of our programmatic areas.

The National Institute of Mental Health, for example, had a citizens participation unit which dealt very specifically with promoting the use of volunteers.

I might ask each one of the Institute directors to comment briefly on that.

Mr. NATCHER. I would like to hear that.

Go ahead, gentlemen.

Dr. BROWN. There are two parts to the question, as I understand. One has to do with the volunteer citizen organization and how they cooperate and participate and the other is the State level.

On the first, in the field of mental health, as you know, the citizen organization, the National Association of Mental Health, claims to have a million members. I think that is accurate. There are divisions in every State and 3,000 local branches of this organization which is active on the community level.

There are other citizen groups interested in related problems such as focusing on autistic children or the retarded child. It has been really the arm of citizen interest and concern that has been behind the Community Mental Health Centers program, for example. In that sense we have done quite well.

We have also worked with the Jaycees and Chamber of Commerce and others.

I think I would like to throw the baton to Dr. Chafetz and Dr. DuPont for their experiences.

ALCOHOLISM AND VOLUNTARY ORGANIZATIONS

Dr. CHAFETZ. The major thrust for really creating the momentum to develop the Alcoholism Institute came from a national voluntary organization called the National Council on Alcoholism that was some 30 years old. And this has led the Institute to devote a great deal of its efforts to developing voluntary and other constituencies.

We have relations with the Jaycees, YMCA, PTA, Federation of Women Clubs, and the Education Commission of the States.

We believe that the implementation of the kind of program that alcohol abuse and alcoholism needs, both the treatment and prevention, require grassroots support and we have heavily invested in developing those.

The States have, as I indicated earlier, been in most instances very responsive in taking their formula grants and developing important service-directed programs but they have also coalesced many of these groups in order to complement what they are doing and we have created, through Federal funding, a venture that ties all the States together so they can be uniform in their reaction along these lines.

Dr. DUPONT. Mr. Natcher——

Mr. NATCHER. Dr. DuPont, before you proceed, I think I have said this, Mr. Chairman, before, in the District of Columbia when we have an unusual person who is exceedingly well qualified for his assignment, as a general rule the Federal Government comes along and steals him. They did with Dr. DuPont. You know he was doing a wonderful job in the District.

Mr. FLOOD. Mr. Natcher is chairman of the Appropriation Subcommittee for the District of Columbia.

Mr. NATCHER. Mr. Miller, you finally get them all.

Go ahead, Dr. DuPont.

Dr. DUPONT. Thank you, Mr. Natcher. It is not likely that I would forget Mr. Natcher's role in the District of Columbia or my appearances before him year after year. He has a great memory for all the promises of the past years and would remind me of those. I still quake a little when I see his face across the table for fear of what is in front of him on the cards.

In the drug abuse field I think one of the striking changes has been that most voluntary organizations have now defined drug abuse as an area of interest and have developed specific programs in these areas both on their own as well as with Federal help.

Part of the problem has been that the initial response of voluntary organizations was based on an exaggerated scare tactic that really was not very helpful. One of the things that we have done is to try to help the voluntary organizations, such as the Boy Scouts and the PTA, to develop credible materials for use in drug abuse prevention activities. To put it very simply, what this effort amounts to is placing emphasis on helping the drug-troubled individual function in society and explaining the risk associated with the use of drugs, including alcohol. In addition, it attempts to point out associated behavior by the individual which jeopardizes his ability to perform in an adequate fashion.

So in drug abuse, also, there has been a major participation of voluntary organizations, which I think makes a tremendous difference in terms of the total community response to the drug abuse problem.

Dr. BROWN. I would pick up the baton back on the other part of the question. One of the things wonderful about the country is the way citizen volunteer efforts bring about government and organizational changes and structure, and this development of the mental health and the alcohol and the drug interest in the community organizations has led to an effect on the State government structure.

ORGANIZATION OF STATE PROGRAMS

Five or six years ago, you had Commissioners of Mental Health at the State level. Now it is hard at times in many States to find a Commissioner of Mental Health. You will find a substantive number of Commissioners of human services or human resources.

We have not yet figured out in the country how to put the things together. One may ask why this confusion. There are good reasons and bad reasons. The good reason is each group wants to do its thing. It is concerned with alcohol and wants to do the alcohol thing or the mental illness thing. I think because of these developments, we are having difficulties as a country in figuring out how to efficiently administer the interface between our programs. That is why I am so pleased to have Mr. Isbister to help to bring us together. We are a bunch of prima donnas—I am talking about the field as well as the people—and he has done a good job trying to interdigitate us and getting us to work together.

EFFORTS TO CONTAIN DRUG DISTRIBUTION

Mr. NATCHER. Thank you.

Gentlemen, in your statements you inform the committee that you are very much concerned about recent evidence of a national resurgence in heroin addiction and are watching indicators of this trend very closely.

Now, from the standpoint of our dealings with other countries, what is being done about this, anything as far as HEW, or is that a matter for the State Department; or where are we?

Mr. ISBISTER. Mr. DUPONT is in a unique position to respond to that because he is the Director of the Special Action Office in the White House on Drug Abuse Prevention as well as the Director of the National Institute on Drug Abuse.

Dr. DUPONT. I am appearing this afternoon before Congressman Lester Wolfe's committee on this very subject because of his concern about Southeast Asia as a supplier of heroin to the United States.

As you probably know, 3 or 4 years ago, the predominant source of heroin in the United States was Turkey, which supplied about 80 percent. As a result of the ban on the cultivation of opium poppies in Turkey, that supply diminished, resulting in a change over the last couple of years in the pattern of heroin supply. Around 60 to 80 percent is now coming into the United States from Mexico. The remainder is supplied from Southeast Asia, the so-called golden triangle centered in Burma and Thailand, predominantly Burma.

I think most of us—I speak for myself, and I believe for the Federal Government as well—were somewhat surprised by the emergence of Mexico as a major supplier. Although it has grown opium poppies and produced heroin for at least 40 or 50 years, the emergence of such a dominance was surprising. As a consequence, primarily because of the shift in the source of supply, the price of heroin in the United States went up fourfold which encouraged an increase in illicit suppliers. We have worked closely with officials of the Government of Mexico, particularly their attorney general. President Ford has also discussed this problem with Mexico's President, and we are pleased with their efforts to help us resolve this issue.

The bottom line, if you will, is that the problem still remains very grave although we are pleased with the efforts the Mexican Government has made in this area.

Mr. NATCHER. Gentlemen, thank you very much.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Conte.

Mr. CONTE. Following up on that, that costs money. We have to give them helicopters, Cessna airplanes and other assistance.

Dr. DUPONT. Technical assistance; that is right. In this regard, 100 Drug Enforcement Administration law enforcement agents were switched from the east coast to the Southwest border to help stem the flow of illicit heroin.

TOTAL FEDERAL EXPENDITURES RELATED TO ALCOHOLISM

Mr. CONTE. You are asking for $653 million here. You know there is a decrease. This is not the only budget that deals in alcoholism, is it?

Dr. CHAFETZ. According to the figures provided from the OMB to the Institute there are a number of agencies, Mr. Conte, that also support both within HEW and the other parts of the Federal Government moneys for the treatment of alcoholism. SRS in HEW provides, according to these figures, $88 million in 1975 as part of their endeavors. The Department of Defense about $9.2; Veterans Administration contends they spend about $41.5. It runs to about $381 million in 1975 according to the OMB figures of the total Federal expenditures on behalf of alcoholism.

However, I would point out according to their figures in 1974 the total Federal commitment was $406 million. In 1975 it is estimated to be $381 million and in 1976 to go down to $334 million.

Mr. CONTE. Does that count DOT, too?

Dr. CHAFETZ. That counts everything.

ACCOMPLISHMENTS IN ALCOHOLISM

Mr. CONTE. Even so, that is a lot of money, isn't it?

Tell me what you have done. What have you accomplished? Alcoholism has been with us since the days of the Greeks and the Romans. Remember, you had Roman chariot drivers going around drunk and causing accidents. What have you done?

Dr. CHAFETZ. Mr. Conte, I am known by my colleagues not to suffer from modesty as one of my problems, and I will be happy to tell you, but I do not want——

Mr. CONTE. Go on an ego trip. Tell me what you've done.

Dr. CHAFETZ. I could go on and give you a lengthy lecture, but I will restrain myself even though it is difficult.

I will give you and the members of this committee some outcome results from our independent evaluation system, that is, the preliminary results which have just been provided to me, and in our treatment programs the recovery rate at 18 months of our alcoholic people is 70 percent. This is measured not only by abstinence and decreased use of alcohol—for example, at intake the figures are 5.6 ounces of absolute alcohol and at 18 months it drops to 1.3, but more importantly, their use of alcohol goes down appreciably. Their employment rate goes up.

As a matter of fact, Mr. Conte, their increased earnings after treatment is more than the money we are putting in from the Federal Government to support these programs.

What is interesting, also, is that there has been an important shift in terms of people who are older, earlier were coming into the treatment programs, and there has been a significant shift to younger people coming in.

At the same time, if you look at the earlier programs as reflected by the drinking-driving programs, the occupational programs, these people who come in, come in and recover at greater rates and at lesser cost.

As far as I am concerned, if you wanted to listen, it would really please you that in 4 years of the Institute's programs, we have accomplished so much so fast with limited resources.

Mr. CONTE. You must be about ready to be phased out, then. Isn't that what usually happens when you accomplish so much?

Dr. CHAFETZ. That is another issue, sir. I must add something.

Mr. CONTE. What is the target date then?

ALCOHOLISM NEEDS

Dr. CHAFETZ. Mr. Conte, please, I must not leave you with the positives without sharing some negatives.

Having devoted 22 years of my professional career to this area, I would be the first to tell you we have a long way to go, because, as you have indicated, this is an ancient problem that goes back to the beginning of history, and I would not want to leave the record or you with

the impression that because we have shown statistically and actually by hard data how much we can help these people, that we have suddenly turned it around and wiped the problem out.

May I remind you, sir, that a simple illness, known as smallpox, which is an acute infectious illness, easy to define and has had a vaccine that is easy to induce, has had that vaccine for 200 years, and the World Health Organization thinks we are about getting rid of it.

So I do not want to leave the committee with the impression—while I have this enthusiasm and have hard data to support the success of the moneys that we have spent—that we have licked the problem. We have a long way to go.

ALCOHOL FUNDING LEVELS

Mr. CONTE. Do you feel you have enough money now to continue on with the breakthroughs that you have made and the knowledge that you have gained so far?

Dr. CHAFETZ. Mr. Conte, I said earlier before you arrived that there is no question in my mind, with my commitment for this programmatic responsibility, that there are important moneys that this field could use. However, I am part of a Federal endeavor; the Congress recognizes and the President recognizes that there are economic difficulties facing this country, and we have to take our share of the licks.

Mr. CONTE. To pick up a wild impossibility, suppose we gave you $1 billion. What could you accomplish then?

Dr. CHAFETZ. Well, I would be loathe to get $1 billion because I believe that there is a gradualism in bringing about the kind of treatment and attitudinal and behavioral changes this field requires, and I strongly believe that too much money too soon spent unwisely and unwell could do us harm.

If you wanted to argue with other figures, I might be able to respond differently.

Mr. CONTE. The reason I asked that question is that I started working on this program in alcoholism in 1950 in the Massachusetts Legislature. That is 25 years ago. We have spent a lot of money. I sit on other committees, and it is a magic word now. DOT maybe shouldn't be in this program at all. We should have one agency in the whole Federal Government handling alcoholism and they are spending money like drunken sailors, speaking of alcoholism, and I am being concerned about the taxpayers, whether we are getting the full value for our dollar.

CHILD MENTAL HEALTH

Mr. CONTE. Mr. Isbister, I was very disturbed to hear your statement that despite a general decline in the inpatient populations of mental health facilities, the number of children under 18 has been increasing. Is this a case of an increasing number of mentally ill juveniles, or a case of better identification and treatment for those who need these facilities?

Mr. ISBISTER. The relatively large numbers of children still being treated as inpatients in mental health facilities is probably due to a combination of several different factors. One of these is the more limited availability of community-based treatment resources for

severely disturbed youngsters as compared to those for adults. A second factor seen as a contributant is the emergence of State laws requiring treatment for emotionally disturbed children. Increasing breakdowns in U.S. families is another factor which is viewed as leading to the relatively high use of 24-hour care treatment facilities for emotionally disturbed children.

Much of the under 18 inpatient population is composed of adolescents. Shifting concepts of mental illness probably account for a number of adolescents who might have previously found their way into the juvenile justice system are now being treated in mental health facilities. Also in recent years, emotional problems of adolescents are seen as often being reflected in more visible problems, like drug abuse.

Mr. CONTE. To what do you attribute the increase in juvenile mental health problems?

Dr. BROWN. The increase in juvenile mental health problems has a multifaceted origin. On one hand, new State laws requiring treatment of juveniles for mental health problems, the shift of adolescents from the juvenile justice system to the mental health system, better identification of problems, and greater utilization of services by parents may account for some of the increases. From a mental health perspective, factors such as the breakdown of the extended family and its supports, the isolation of the nuclear family, the greater mobility of our society, and such societal stresses as our present economic crisis are thought to be other components of the picture.

In other words, part of the increase in juvenile mental health problems is secondary to changes in legislation and the human service systems, making existing problems more apparent. Another part of the increase is real; an actual increase in problems secondary to rapid social change and related social stresses.

Mr. CONTE. Are there any particular types of mental illness to which young people seem especially suspectible?

Dr. BROWN. There are particular dramatic mental health problems that manifest themselves in young people, often affecting their lives and social functioning as adults. These are the schizophrenias; infantile autism; the hyperkinetic disorders; and the uncommon but difficult to treat disorders of eating and substance abuse. Depression is a poorly documented, little understood entity in young people. It is associated, however, with dysfunction in school, antisocial behavior, and suicide. Finally, it should be noted that all children and adolescents are susceptible to transient disturbances as part of meeting the challenges of normal development. For some, transient disturbances are significantly disruptive to normal development and family functioning, increasing greatly the vulnerability of child and family. In such situational disturbances therapeutic intervention is necessary to prevent the development of overt mental illness and/or relative social dysfunction.

PREVENTIVE MENTAL HEALTH

Mr. CONTE. I think that we would all agree that in the long run, prevention of a health problem is better than curing one after it occurs. Would you tell me what is being done in the area of preventive mental health, and what could be done if we had the resources?

Dr. BROWN. Mr. Conte, as the Institute's name indicates, the National Institute of Mental Health places a good deal of importance on understanding the basis of, and promoting, positive mental health. In a sense, most of its programs may be called preventive. In research, a promising approach is that of identifying high-risk groups and studying them over a period of time to find out what enables some to resist illness while others become mentally ill. In NIMH's crime and delinquency programs, emphasis is on understanding and treating problem behavior before it results in serious acts of delinquency or crimes. We are also trying to develop model prevention programs. In one area of special interest to you, Sudden Infant Death Syndrome, we are working to develop a model effort to prevent serious emotional problems in families that have lost an infant in this manner. Community Mental Health Centers' consultation and education services are a major prevention effort. To help centers stabilize these important programs, we are planning to evaluate financing mechanisms for such services.

ACCESS TO ALCOHOLISM TREATMENT

Mr. CONTE. Mr. Isbister, you told us that there are now nearly 700 federally funded alcoholism service programs in the United States. Could you estimate what percentage of our population has reasonable access to an alcoholism service program? How many programs would be needed to provide essentially total population coverage, or say 90 percent coverage? How much would it cost to provide that kind of coverage, if the difference were going to be made up by federally-funded programs?

Mr. ISBISTER. The nearly 700 federally funded alcoholism treatment projects along with those funded by other sources are spread throughout every State. Although the Institute has not yet developed figures as to the actual percent of the total population served, we do know from monitoring these programs and selecting projects that are in areas where alcohol services do not exist that a large percentage of the population now has access to alcoholism services. However, that is but one factor in realistically providing access for alcoholic people. Our recently completed special client followup study supported a long-held contention—that it is critical to be responsive to the client's wishes regarding treatment setting, types of staff and the like. Individuals and groups have varying needs which imply a variety of treatment programs for maximum impact. Furthermore, the followup study showed that the frequent reason cited for dropping out of treatment involved the complications of attending treatment, for example, transportation, job requirements, and so forth. These problems must be solved if reasonable access to treatment is to be achieved.

Our studies of the comprehensive treatment centers show a cost of $400–$500 per successfully treated client. Taking into account our estimates of how much this cost can be reduced and the varying complexity of service required by people with different alcohol problems, it is estimated that $2–3 billion would be required to treat the current alcoholic population. However, I would hesitate to agree that this degree of coverage is the direct responsibility of the Federal Government. Our objective is to stimulate greater efforts at the State and local levels to develop their own capacity for providing services for alcoholism afflicted persons.

We are also experimenting to find more effective ways of providing mental health information to hard-to-reach groups. We are developing prevention content for health and mental health training programs, and helping States develop administrative focal points for prevention in State mental health departments. Right now, only three States, one of which is Massachusetts, have formal primary prevention programs at the State level.

COMMUNITY MENTAL HEALTH CENTERS

Mr. CONTE. To what extent are alcoholism services and treatment provided through the community mental health centers program?

Mr. ISBISTER. A total of 137 community mental health centers provide alcoholism programs. Another 92 CMHC affiliates provide such programs.

FEDERAL ROLE IN ALCOHOLISM TREATMENT

Mr. CONTE. If I may address this to Dr. Chafetz, given the limited resources available from third-party payments and funds allocated by State and local governments for alcoholism programs, what do you believe the Federal role should be in the prevention and treatment of alcoholism?

Dr. CHAFETZ. As you suggest, Mr. Conte, the availability of resources for alcoholic persons from third-party payments and from State and local governments is extremely limited. Data gathered from five of the Institute's community projects highlights the extent of these limitations. Thus, in the Alcoholic Treatment Centers, Institute funds cover 49 percent of the operational costs of the projects. The percentages increase for the remaining four programs, to 71 percent in the drinking driver program, 73 percent in the occupational industrial program, 90 percent in the public inebriate program, and almost 99 percent in the Institute's American Indian program. In other words, during 1974 the extent of third party, State and local government resources committed to these programs ranged from a little over 1 percent to 51 percent.

The Institute's demonstration effort has supported a significant number of projects for 3 years which have proven their effectiveness. The effect of these projects has been to increase the Nation's awareness of the problems of alcoholism and to build State and local capacity to handle the problems. While the fiscal year 1976 budget represents a decrease in the Federal effort, it must be realized that the purpose of the Federal program is to develop awareness and demonstrate new and better methods of prevention, treatment, and rehabilitation, not to provide long-term support for what is properly a State and local responsibility. On the other hand, I am supportive of the passage of national health insurance, since this represents a funding base which would facilitate efforts at the State and local levels to develop alcoholism treatment capability.

It must be recognized, however, that certain poverty and minority groups are limited in their ability to negotiate with State and local government bodies and the overall health services delivery system. For these groups an advocacy role, together with funding support, must be maintained by the Institute until these groups can develop a viable negotiating status with nonFederal funding sources.

The implementation of a national health insurance program appears to be a real solution to the long-term funding of alcoholism services. In the absence of such legislation, however, the Federal Government should continue to fund demonstration projects to address the prevention and treatment needs of alcoholism and alcohol abuse in this country. Special efforts must be undertaken, as the Institute is now doing through the model insurance benefit policy, to demonstrate to the insurance industry the economic feasibility of extending insurance coverage and benefits to the alcoholic population. Institute efforts to bring about coverage by private carriers are assisted by an increasing consumer demand brought about by the influence of the projects, the employees of alcoholic individuals, and the benefiting communities. Yet another role that the Federal Government should play is in the public education and information field by continuing to make the American people aware of the extent and prevalence of alcohol use and abuse. Finally, the Federal Government should continue to stimulate and encourage the assumption of increasing shares of the costs of alcoholism projects by State and local government. As the No. 1 health problem of this country, States should be prodded towards reorienting their priorities so as to more adequately address the social and health consequences of alcohol use and misuse.

OCCUPATIONAL ALCOHOLISM PROGRAM

Mr. CONTE. I have received some excellent reports from people in my district about the effectiveness of the occupational alcoholism programs. How much money do you intend to spend on occupational alcoholism programs this year? How does that compare to last year? What are you requesting for 1976?

Dr. CHAFETZ. We anticipate funding a total of 50 occupational alcoholism projects in the amount of $4.7 million in 1975, including 27 from 1973 released appropriations which were available for obligation until February 7, 1975. This represents a decline of 28 grants and $1.8 million from the 1974 level. However, nearly all of the State occupational programs which were given a third year of funding in 1974 will now receive their continuing support from the States. So, in effect, we have an expansion of this program in 1975. In 1976, existing grants will be continued at a substantially reduced level, and there are no new starts budgeted.

Mr. CONTE. Could you provide us with a description of the operation and results of some of your occupational alcoholism programs?

Mr. CHAFETZ. In the selection of occupational alcoholism programs for grant support, we have been guided by our need to develop new techniques and settings for the earlier identification of workers in trouble with alcohol, particularly before they were faced with the alternative of termination.

A case in point is our 3-year grant to the Air Line Pilots Association (AFL–CIO). This project proposes to establish an alcoholism intervention and motivation demonstration program which will develop techniques for dealing with the problems of alcoholism and alcohol abuse in the airline pilot population, aiming at the earliest possible case detection, prevention, and facilitation of intervention. The grant is still in its first 6 months of development. Both the Institute and the grantee organization are very encouraged with what

has been accomplished to date. A second labor-directed grant is one being administered by the International Longshoremen's Association covering its work force in Manhattan, Brooklyn, Newark, and Hoboken, in cooperation with the New York Shipping Association. The association is administering the program through the union stewards, who act as liaison between the worker and management in a role similar to that of supervisor. Like the Air Line Pilots Association program, this project is in its first 6 months of operation.

All grant programs are not in large cities. A case in point is a grant awarded to the York County Council on Alcoholism in Rock Hill, S.C. This local council is undertaking to create a program which will cover the work force employed in a number of small industries in York County. With a staff of three, the council will provide all the services needed for the approximately 10,000 workers employed in 5 local companies engaged in different manufacturing processes. This grant is an effort to test one way of servicing the work force of smaller industrial establishments and still provide effective and inexpensive programs to meet the needs of the employer and employee. The total 3-year budget for this grant is $61,365. At the end of that period, local industries are expected to support the program.

The State of Kentucky alcoholism agency informs us that it now has regional health centers throughout the State, each staffed with an occupational consultant and support staff which can provide services similar to that provided by the York County Council on Alcoholism to any employer on an annual per capita fee basis. For instance, grocery or other retail chains could contract to be provided with a program which would cover all of its employees throughout the State.

At the other end of the spectrum, in 1974 we funded a grant to the New York State Division of Alcoholism called the New York City Corporate Headquarters Project. This is an effort to reach top management in the large corporations of the country, which are largely headquartered in New York City. Experience has shown us that these key decisionmakers present a special problem in selling a program such as this. Some of these corporations already have effective programs. For instance, the four top executives of the Association of Labor-Management Administrators and Consultants on Alcoholism I mentioned earlier are the program directors of Standard Oil Co. of California, General Motors Corp., ITT, and Hughes Aircraft Co.

Mr. CONTE. How many additional occupational alcoholism programs do you intend to fund in 1976, compared to fiscal 1975?

Dr. CHAFETZ. The 1976 President's budget would allow the funding of 40 occupational programs at reduced levels. In addition to the reduced continuation costs, the 1976 budget estimate represents a decline of 10 projects from the previous year, since the 1975 level includes 23 projects from regular 1975 appropriations and 27 new projects funded with released 1973 appropriations. The 10 terminated projects would have to obtain non-Federal funds for their support beyond fiscal year 1975.

EVALUATION OF ALCOHOLISM TREATMENT TECHNIQUES

Mr. CONTE. Mr. Isbister, you mentioned the monitoring of NIAAA-supported alcoholism treatment programs to evaluate the effectiveness of various treatment approaches. Can you tell me what you have

found from this monitoring? Do you have any implications of what treatments appear most effective, and how are you gearing your overall program toward such methods?

Mr. ISBISTER. The monitoring of NIAAA-funded projects has provided significant information on the effectiveness of treatments for the various populations concerned. Those populations range in terms of debilitation from the public inebriate, or skid-row person, to the drinking driver group which shows the least effect from alcohol-related problems. We have found that 180 days after intake at an alcoholism treatment center, there is an increase of 13 percent in the number of clients employed and also an increase in dollars earned, and decreases in the amount of alcohol consumed per day. In fact, the total additional client income reported by the alcoholism treatment centers for 1974, $11,513,484, is equivalent to the amount obligated by the Institute for these centers in fiscal year 1974.

It has been found that persons reporting drinking heavily for over 5 years require significantly more treatment than those drinking fewer than 5 years and the same degree of recovery cannot be expected.

The use of outpatient services to treat persons suffering from alcoholism has proven quite effective and the Institute is emphasizing outpatient rather than inpatient service where appropriate. The use of alcoholism counselors also has proven particularly effective. Emphasis has been placed on a greater use of counselors instead of higher paid staff professionals and training of counselors has received a high priority. Group counseling has benefited most clients to the same degree as individual counseling and therapy. Therefore, group sessions are emphasized in all program areas and are proving successful.

As a result of these findings regarding the effectiveness of various treatment modes, more persons are being served than before and the costs of those services have decreased dramatically.

ALCOHOL MODEL INSURANCE BENEFITS PACKAGE

Mr. CONTE. Can you tell me what is included in your model benefits package for insurance coverage of all alcoholism treatment?

Dr. CHAFETZ. NIAAA has developed a model alcoholism benefit package which reflects the current state of the art in the alcoholism field. This benefit package does not represent a policy statement by NIAAA, but is a practical measure obtained by analysis of present treatment programs to provide some basis for projecting a reasonable range of the costs of covering alcoholism treatment in the various settings.

Determining alcoholism treatment costs is especially difficult because they vary greatly from program to program. A recent study provides some information concerning the costs of different types of alcoholism treatment programs compared to the model benefit package. A preliminary conclusion from this study is that it is reasonable and economical to provide care for alcoholism through the vehicle of the model benefit package in certain types of settings.

In order to obtain additional data on treatment costs, NIAAA is discussing with both the Health Insurance Association of America and National Blue Cross Association a program whereby selected carriers will open up full coverage for alcoholism treatment to limited enrolled groups. Actuarial costs of providing such coverage will be

analyzed under contract, and the information gained will be offered to the insurance industry to assist them in determining the costs of this coverage.

The model benefit package projects, as the basis of treatment, the following maximum lengths of stay: Inpatient emergency care—6 days; Inpatient care—14 days; Outpatient care—30 visits; Intermediate care short term—30 days; Intermediate care long term—60–90 days.

Mr. CONTE. Can you tell me how many people are actually covered by this level of benefits. Would you recommend that this model benefit package be included in a national health insurance program?

Dr. CHAFETZ. Since medicare, medicaid, private insurance, and HMO's have not traditionally covered alcoholism, there is limited data available at this time to determine coverage and utilization rates. California has recently initiated a pilot alcoholism occupational health insurance program for all State employees, based on a modified version of NIAAA's model benefit package. The insurance covers alcoholism as a primary diagnosis for employees and all family members, totaling over 300,000 persons. The benefits for this program include: Detoxification care, 6 days; general hospital care or care in specialized alcoholism treatment centers, 21 days; care in a recovery home or other residential facility, 30 days; outpatient care, 45 visits.

Concerning the second part of your question, we believe it would be premature to include the model benefits package in its current state today in a national health insurance program. Until the benefits package has been tested and properly revised and expanded, it should be viewed as a concept or framework upon which NIAAA policy will be developed. However, we fully expect that within the next year or two, a fully tested model benefits package will be available for inclusion in a national health insurance program.

JUVENILE USE OF ALCOHOL

Mr. CONTE. I think one of the most disturbing trends in alcohol abuse is the increasing numbers of juvenile abusers of alcohol. Can you provide some statistics on the size of this increase?

Dr. CHAFETZ. Alcohol use and abuse among young people has been increasing over the years. This is primarily due to two factors; the natural increase in the number of adolescents in the United States through population growth, and the downward trend of alcohol usage into the lower grades—that is, from the 4th through 9th grades. The proportion of alcohol users has remained fairly constant among senior high school students since the fifties. In 1953, 89 percent of the seniors in New York City drank alcohol. Similar results were obtained in a 1955 Wisconsin study. This compares to 90 percent of the seniors surveyed in a 1974 national probability study conducted by the Institute. The numbers of abusers have been increasing, however.

Studies indicate that abuse of alcohol in San Mateo, Calif., rose from 15.6 percent of the students in 9th through 12th grades in 1970 to 28.1 percent for the same grades in 1973, or a 180-percent increase. In Toronto, Canada, the abusive alcohol rate rose from 36 percent in 1968 to 82 percent in 1972. A 2-year study in the Jacksonville, Fla., area showed that abusive alcohol users in junior and senior high school rose about 21 percent for males and about 11 percent for females.

Mr. CONTE. To what do you attribute this increase in juvenile drinking?

Dr. CHAFETZ. The increase in juvenile drinking seems clearly related to a social atmosphere of permissiveness and even of encouragement of teenage drinking, the availability of alcohol, and, even more clearly, to the fact that drinking is widely accepted and practiced by adults.

There are other factors, I am sure, which are less apparent—alienation, defiance of parents, emotional problems, peer pressure. Generally speaking, teenages are going through a period of particular stress and uncertainty and are less likely than adults to exercise judgment and restraint. Under these circumstances, the influence of one or more of these factors can lead to increased abuse of alcoholism.

Mr. CONTE. What can be done about the juvenile drinking problem? What do you intend to do in this area in 1976? How much money will be spent on juvenile alcoholism prevention and treatment in 1976, and for how many programs?

Dr. CHAFETZ. The quality and organization of treatment programs for young people with drinking problems is in need of modification. Four priorities have been identified which would address this need for modification of how juvenile drinking problems are handled. Their priorities include: The development of prevention and treatment program guidelines for children and youth; increasing the interdigitation of alcohol prevention and treatment programs with drug abuse and juvenile delinquency prevention programs; increasing the access to alternative forms of service programs; and studying in greater depth the alcoholic child and the behavior disordered child in order to develop effective prevention and intervention strategies.

In recognition of the growing problem of alcoholism among youth, the Institute has established special treatment programs which focus on the special problems of young people. The Institute will award three youth treatment projects in fiscal year 1975 in the amount of $771,000. These programs will be continued in 1976 at a reduced level.

In the prevention area, a total of 13 grants will be supported in 1975 and 1976. These projects involve health, educational and law enforcement agencies, providing outreach to identify early alcohol problems among young people, and intervention programs in schools and other youth oriented organizations.

The Institute has developed collaborative efforts with the National Congress of Parents and Teachers, the Junior Chamber of Commerce and the YMCA, and provides a variety of youth oriented materials and services through the National Clearinghouse for Alcohol Information. These efforts will continue in 1976 at a reduced level.

INCREASE IN HEROIN ADDICTION

Mr. CONTE. Mr. Isbister, you mentioned recent evidence of a national resurgence in heroin addiction. Would you provide us with that evidence? Do you have any explanation for this increase?

Mr. ISBISTER. Predictions of increase in heroin addiction in the United States are based upon the recent fluctuation of six key indicators. The Drug Enforcement Agency's latest estimate of total active heroin users in the United States indicates that their number increased from 602,000 in 1973 to 725,000 in 1974. The price of heroin has gone down in the eastern United States and remained constant in the cen-

tral, northwestern, and western United States, suggesting an increase or continued supply of heroin in the street. Heroin purity is up to 7 percent in the east, suggesting greater availability. Emergency room incidents involving heroin episodes rose 66 percent during the July–September 1974, period compared to the same period in 1973. A recent FBI report indicates that property crime, often associated with the illicit purchase of narcotics, accelerated in 1974 following a period of slowed growth. The projected number of cases of hepatitis type A and B was 61,100 in 1974 compared to 59,200 in 1973. Primarily, this increase can be explained by the spread of Mexican brown heroin into both larger as well as some smaller U.S. cities, and the resumption of Turkish production.

Mr. CONTE. If we devoted more efforts to narcotics enforcement, including better customs control, would this help the addiction problem? Or would it simply raise the price of an addict's habit?

Dr. DUPONT. Supply reduction is an essential part of our overall national drug abuse prevention strategy. We measure supply reduction success by increases in the price of illicit drugs. Thus, more successful narcotics law enforcement, including better customs control, would definitely help the drug abuse problem. Evidence is that, when the price rises, the number of people using illicit drugs decreases and those who continue to use do in fact use less. To some extent these gains are offset, because raising prices force some addicts to commit more crimes to pay for the more expensive drugs. For example, in the District of Columbia when the price of heroin rose from about $1 per milligram to about $8 per milligram between 1971 and 1973 the average habit of the active addicts entering treatment rose from about $45 to $55 per day. There were many heroin addicts in Washington who came into treatment or just gradually stopped using heroin because of the dramatic rise in cost. The net effect of these complex events was a sharp drop in the crime rate in the city. I will provide as an insert for the record a study which also shows that when the price of heroin dropped in the District of Columbia during the last year the crime rate rose again.

[The information follows:]

THE RESURGENCE OF HEROIN ABUSE IN THE DISTRICT OF COLUMBIA

(By Mark H. Greene, M.D., Bureau of Epidemiology, Center for Disease Control, U.S. Public Health Service, Atlanta, Ga.[1])

ABSTRACT

Prospectively collected drug abuse trend surveillance data suggest that the rate of heroin use in Washington, D.C. is rising following a 2-year decline in the magnitude of this problem. Supportive data include increased potency of street level heroin, increased numbers of heroin-related deaths, increased detection of heroin positive urine specimens in the District of Columbia Superior Court arrestee population, increased demand for addiction treatment services and rising property crime rates. Increased prevalence of heroin use has not yet been associated with an increase in incidence, suggesting that former heroin users have begun to use once again following a period of abstinence.

Analysis of heroin specimens seized across the Uinted States suggests that cities formerly dependent upon European (white) heroin have now developed a new heroin distribution system which supplies Mexican (brown) heroin. This

[1] On special assignment in drug abuse epidemiology to the Special Action Office for Drug Abuse Prevention, Executive Office of the President.

has offset the reduction in heroin use observed during 1972–73 concomitant with the east coast heroin shortage and widespread introduction of addiction treatment services.

INTRODUCTION

Drug abuse authorities in Washington, D.C. have had a unique opportunity to study the dynamics of heroin addiction in this city. The systematic, prospective collection of heroin use trend data has permitted ongoing analysis of the nature and extent of heroin addiction during a period when enormous resources (both treatment and law enforcement) were brought to bear on this problem. The status of heroin addiction in Washington at the time intervention was undertaken has been previously described in this journal (1), and the subsequent decline of heroin abuse in Washington has been reported elsewhere (2, 3). The rationale underlying the application of epidemiologic techniques such as surveillance to the study of heroin addiction has also been discussed in detail (4).

The District of Columbia Drug Abuse Surveillance System has recently detected an increase in heroin abuse in this city. Data will be presented to support this assertion, and the implications of these observations with regard to the natural history of heroin addiction and the efficacy of various intervention strategies will be discussed.

METHODS

Details regarding data collection methods and definitions for the Drug Abuse Surveillance System and its components have been previously reported (2, 3, 5, 6). The analysis of year of first heroin use data as an indicator of the relative incidence of new heroin use has also been described in detail (7). In brief, data are collected prospectively from the following sources:

(1) Patients entering treatment with the Narcotics Treatment Administration (NTA) heroin addiction treatment program;

(2) Urine testing programs for heroin in three locations: NTA Central Medical Intake, the District of Columbia Superior Court Lockup, and the District of Columbia Jail;

(3) District of Columbia Examiner's reports on deaths due to acute opiate overdoses; and

(4) District of Columbia Metropolitan Police data on property crime, narcotics arrests, heroin seizures and undercover heroin "buys" at the street level.

Both the treatment and law enforcement efforts with respect to heroin addiction began in 1969, grew rapidly through 1971, and remained constant at that level through the end of 1973. Since then, there has been a decline in the number of undercover agents working on the narcotics squad. In addition, agents have been instructed to be more selective in making undercover heroin "buys," focusing on purchases that are more likely to produce an arrest with a probability of conviction. There have been two major changes in the treatment program, the first being a reduction in both the number of clinics and treatment slots following the decline in demand for treatment observed in 1973 (2, 3), and the second being the elimination of all methadone take-home privileges in July 1974.

In addition, natural data on laboratory analyses of heroin specimens have been provided by the Federal Drug Enforcement Administration (DEA). These data are obtained from DEA Regional Laboratories, which analyze heroin specimens seized or purchased by DEA field agents. Specimens undergo quantitative analysis with respect to heroin potency and qualitative analysis aimed at identifying non-opiate diluents used in the illicit manufacture of heroin.

Data were analyzed for statistical significance using the student t test and the chi-square test. Trends were shown to occur with a linear regression line, fit by the method of least squares. Significance of trends was tested with Pearson's correlation coefficient.

RESULTS

This data collection system has been used to document the downward trend in heroin use that occurred in the District of Columbia in 1972–73 (2, 3). This decline in heroin use has been attributed to the combined impact of the east coast heroin shortage and the widespread availability of heroin addiction treatment services. Recently, however, there have been indications that rates of heroin use in Washington are once again on the increase.

Figure No. 1 depicts the average purity of heroin purchased at the street level by narcotics squad undercover agents on a quarterly basis from mid-1969 through the end of 1974. The downward trend in purity through the end of 1973

is highly significant ($r = -0.94$, $p. < .001$). However, there now have been three consecutive points outside the 95 percent confidence band around this trend line, suggesting that the purity of street level heroin has increased significantly in the District of Columbia during 1974. This is corroborated by the observation that the average number of milligrams of pure heroin present in street level heroin packages, which had fallen from a maximum of 13.4 milligrams (April 1972) to a minimum of 2.5 milligrams (in September 1973), has now risen to 6.0 milligrams (4th quarter, 1974).

The death rate from heroin-related overdoses is shown in figure No. 2. All cases had morphine and quinine identified at post-mortem toxicologic analysis. Note that the heroin overdose death rate declined steadily from mid-1971 through mid-1973. There were 18 heroin related deaths in 1974, compared to 5 such deaths during the entire year of 1973. In 16 of these 1974 cases, heroin was the only opiate detected. In 2, methadone was also present. It is of further note that 14 of these individuals were known, chronic narcotics users. The other 2 had the cutaneous stigmata of chronic parenteral drug abuse but were not known to NTA and were not reported to be drug users by family or friends interviewed during the death investigations. That most of the deaths occurred among long-term heroin users, rather than among opiate-naive experimenters, is supported by the high average age of these victims. During 1971–73, the average age of heroin overdose death victims was 25.0. In 1974, it increased to 27.4 ($t = 1.70$, $p. > .05$).

The most reliable urine screening program for heroin in the city is that run in the District of Columbia Superior Court (see figure No. 3). Once again, the downward trend in the detection of heroin (morphine and/or quinine) in this facility is highly significant through the third quarter of 1973 ($r = -0.860$, $p. < .01$). Since that time, there has been an increase in the number of heroin positive urine samples. There are now three consecutive points outside the 95 percent confidence band around the previous trend line, suggesting that this is a significant increase.

The demand for services at NTA peaked during the first quarter of 1972, during which an average of 33 heroin users were admitted for treatment each day. The nadir of demand for treatment services was reached in the last quarter of 1973, with an average daily admission rate of 9 patients. Treatment demand has begun to rise once again in 1974, with an average of 12 patients being admitted each day during the last quarter of 1974.

The proportion of heroin among all seizures of illicit drugs made by the District of Columbia Metropolitan Police is illustrated in figure No. 4. Note once again the sharp decline in heroin seizures from 1971 through the end of 1973. During 1974 there has been a small but statistically insignificant increase in the proportion of heroin seizures.

The number of opiate charges[1] made by the District of Columbia police reached a peak of 3,114 in 1971. This figure declined to 2,108 in 1972, with a further decrease in 1973 to 958 (see table No. 1). Based on data available through the first three-quarters of 1974, there will be an estimated 900 opiate charges for the entire year.

Although the relationship between property crime and heroin addiction remains poorly elucidated, it is clear that contemporary heroin users are deeply involved in criminal activity, the majority of which is property crime rather than violent crime (5,8,9). There has been a very close parallel between trends in heroin use and reported property crime in the District of Columbia (see table No. 2). Property crime peaked in 1969 and declined steadily in the 3 years that followed, following the same pattern as heroin use incidence. In 1974, when heroin use began to increase again, property crime in Washington increased for the first time since 1969–70. We have demonstrated previously a negative correlation between enrollment in NTA and property crime in Washington (2).

As the number of addicts in treatment increased, the number of crimes associated with addiction decreased ($r = -0.79$, $p < .001$). Perhaps more striking is the relationship between the purity of heroin purchased by undercover agents and the number of reported burglaries in the city (see figure No. 5). As the purity of heroin increases the number of burglaries reported increases. There is a highly significant positive correlation between these two variables ($r = +0.92$, $p < .01$). The potency of heroin at the street level is felt to be an indirect indicator of the number of heroin users present in the community (10, 11), since increased

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[1] These charges are simple possession of heroin, possession of heroin with intent to distribute, and sale of heroin.

potency implies increased availability, and increased availability is probably associated with increased levels of use. To the extent that increased heroin potency is associated with increased prevalence of heroin use, one might expect to see an increase in the number of crimes (burglary, for example) normally committed by addicts, when heroin potency rises. And, in fact, this is what we have observed.

The data presented thus far are indicators of the relative prevalence of heroin use (10). That is, they are thought to reflect increases or decreases in the total number of heroin users in the community. A critical question in the light of evidence which suggests increased heroin use relates to who the users are. That is to say, does the increased level of use reflect the return of former heroin users to habits they had either reduced or discontinued, or does the increased level of use reflect the creation of new heroin users? To assess this question, year of first heroin use as reported by addicts entering treatment with NTA for the first time can be used.

The distribution of year of first heroin use has been found to be a good indicator of relative heroin use incidence (7, 12), particularly if correction is made for the known lag between the onset of heroin use and subsequent entry into treatment. Figure No. 6 displays this distribution for all heroin users admitted to NTA from its inception through October 1974. The modal year of first heroin use is 1969, with a steady decline in the number of those who report onset of their heroin use in subsequent years. Even when this distribution is corrected for the lag between onset of use and entry into treatment (see dotted line), the number of individuals with recent onset of heroin use is very low. This suggests that the increased level of heroin use documented by the prevalence indicators is not associated currently with an increase in the incidence of heroin use.

Further corroboration of this apparent increase in the prevalence of heroin use without a concomitant increase in the incidence of new heroin use is provided in an analysis of the age trends among patients first admitted to NTA (see table No. 3). Since heroin use in general has its onset in the mid to late teen years (modal age of first heroin use in Washington is 17), the mean age of heroin users first admitted to treatment tends to be low or declining if the incidence of new use is high. If incidence is low, and there has been an epidemic of new use in the past, the age of newly admitted users tends to increase as time passes, since there are very few new (i.e., young) heroin users being created. The age distribution among NTA first admissions substantiates our contention that, at the moment, incidence is low. The mean age, increased steadily since 1972, after the peak of new use had passed.

DISCUSSION

In our previous publications, we have documented the existence of what can properly be called an epidemic of heroin use in the District of Columbia. This epidemic reached its peak in 1969, since which time the incidence of heroin use in this city has declined steadily. Data obtained through the city's Drug Abuse Surveillance System also suggested that the prevalence of heroin use declined somewhat later, in 1972–73 (2–4). Reasons offered for this observed decline in heroin abuse included the widespread availability of comprehensive, multimodality addiction treatment services and the impact of local, national and international law enforcement efforts which resulted in a sharp decrease in the availability and quality of heroin, particularly on the east coast of the United States (11). In addition, there has been some theoretical work to suggest that one might expect heroin epidemics to be self-limited (at least in terms of the creation of new users) as the number of susceptible individuals in the community is exhausted (13).

Data presented above suggest that there has been a recrudescence of heroin use in Washington, D.C. during 1974. This is supported by finding significant increases in the purity of heroin available at the street level, number of heroin-related overdose deaths, number of urine specimens found to contain morphine and/or quinine in the District of Columbia Superior Court, rising demand for addiction treatment services and an increase in the types of property crime traditionally assumed to be related to heroin addiction. These indicators of increased prevalence of heroin use are not, at least for the moment, associated with an increase in the number of new heroin users being created in the city.

The low level of incidence is supported by the analysis of year of first heroin use distributions (with lag corrections) and the analysis of the age distri-

butions of addicts first admitted to NTA's treatment program and addicts dying from heroin overdose. This finding emphasizes the chronic, relapsing nature of heroin addiction since the increase in heroin use is occurring among addicts who had either discontinued or substantially reduced their heroin use during the recent period of heroin scarcity.

Similar increases in the prevalence of heroin use have been reported recently in San Francisco and Boston (14, 15). However, in both of those cities, increased prevalence of heroin use has been associated also with an increase in incidence. This suggests that the District of Columbia may be in a transitional phase, and that if increased availability of heroin persists, incidence will begin to rise here as well.

What explanations can be offered for this increase in heroin availability? It would appear that the scarcity of heroin during the past 2 years was related to the impact of disrupting the French-Corsican heroin distribution system. It was this distribution system which supplied the bulk of heroin to most of the cities along the east coast of the United States and northern California. The heroin that was produced by this system was white in color, had a fine, powdery consistency, and was most frequently diluted with lactose and quinine. According to chemists at the Drug Enforcement Administration, there also have existed for many years other heroin manufacture and distribution systems. One of these traditionally supplied heroin to the Southwest, southern California, and to a lesser extent, the Midwest.

The heroin produced by this system was brown, had a coarse, granular consistency, and was generally diluted with lactose and procaine. The major portion of this heroin is thought to be produced in Mexico. Prior to the east coast heroin shortage of 1972–73, brown heroin was found only rarely on the east coast, and when it was, east coast heroin users would not use it. Similarly, west coast heroin users would not use white heroin. This situation appears to have changed significantly over the past several years. Figure No. 7 illustrates this change: note that brown heroin has come to comprise the majority of heroin samples obtained by DEA agents all over the country. One can literally watch this distribution system work its way across the United States. This change has been accompanied by an attitudinal change among east coast heroin users who, motivated by the scarcity of the white European heroin, have come to view the brown Mexican heroin as highly potent (which it certainly is) and highly desirable. It would appear, then, that the increase in heroin availability documented in Washington is related to the replacement of one distribution system by another. A significant proportion of the heroin currently available in Washington is of the brown (Mexican) type. The fact that an increase in heroin availability was immediately followed by an increase in heroin use, sheds a great deal of light on the role of heroin availability in perpetuating addiction as a major social problem. The data suggest that the law enforcement efforts aimed at reducing heroin availability may have played a greater role in reducing the magnitude of the heroin problem along the east coast than was previously appreciated.

There has been a great deal of skepticism expressed regarding the purported national decline in heroin use during the past 2 years. The most compelling data supporting the existence of such a decline are local or regional in nature. Major cities like New York, Boston, Washington, San Francisco, Chicago, and Atlanta all have reported a sharp decline in both the incidence and prevalence of heroin use during 1972–73. Areas like these contain a sufficient proportion of the Nation's heroin users that there may have been a net national decline in the number of heroin users during the same period. However, it is clear that there were areas of the country that did not experience such a decline during that time (12, 16, 17). Heroin abuse (and drug abuse in general) is such a heterogeneous phenomenon, with so much variability from city to city and region to region, that speaking in national aggregate terms may obscure more than it elucidates. The important observation is that in many cities the incidence and prevalence of heroin use declined in association with intensive intervention by both the treatment and law enforcement communities. The east coast heroin shortage was real, and it persisted for a remarkably long time. It was accompanied by a significant decline in the magnitude of the heroin problem in those cities that were affected. The implication is that repeated disruption of major heroin distribution systems can reduce the availability of heroin, making the heroin that is available less potent and more expensive. The reduction in heroin availability can contribute substantially to reducing the size of the heroin-using population.

Whether society is willing to support the size and quality of the law enforcement effort required to accomplish this end is another question entirely. The facts

do suggest that such an effort can have significant impact if society feels that such goals are important. In general, those cities which had persistent, high heroin use prevalence during 1972–73 had either continued high availability of potent, relatively inexpensive heroin, or lacked a massive infusion of addiction treatment services, or both.

A critical question raised by these observations is that if the whole problem hinges on heroin availability, with heroin use increasing as soon as availability increases, doesn't this imply that the whole effort directed at treatment of heroin addiction has been an enormously expensive failure? Unfortunately, the data to answer such charges are not available. The heroin use indicators employed in this discussion only speak to relative trends in heroin use. We do not have the techniques for accurately measuring the absolute number of heroin users at any given point in time. Thus, we can say only that the problem is increasing, but we really can't say by how much. We must learn how many former users have begun to use again now that heroin is more accessible. We would like to know how many of those who have not relapsed into heroin use would have relapsed if they had not been exposed to treatment during the heroin shortage. We can only speculate regarding the consequences of reduced availability if heroin users had not had some alternative to what could have become an increasingly frantic and desperate lifestyle during a severe heroin shortage with no treatment services available. Although the absolute magnitude of the current increase in heroin use cannot be precisely defined, it does not appear to be considerably smaller than when the problem was at its worst in 1969–71. Conceivably, the relapse would have been more explosive had it not been for the existence of citywide addiction treatment services during the past 5 years. These are researchable issues, however, and a number of followup studies currently underway offer an opportunity of resolving some of these as yet unanswered questions. Given the chronic relapsing nature of heroin addiction, one should not overreact to observations such as those presented here, with a blanket condemnation of the heroin treatment effort. More data are required before a reasonable assessment of this issue can be made.

Finally, let us consider for a moment several important implications in these data with regard to the heroin intervention strategy here in the District of Columbia. First, it is important to note that in the face of evidence of rising heroin use, the number of heroin seizures and opiate charges made by the D.C. Metropolitan Police have not increased significantly. This may mean that the other indicators are misleading, but it more likely implies some changes within the local criminal justice system. There has been a decline in the number of undercover agents during the last half of 1974, and a shift away from buying heroin whenever possible, toward buying only when a good case can be made. This reduction in manpower and modified "buy" policy could account for the low number of heroin buys and seizures. In addition, it is possible that the development of a new system for the distribution of heroin has brought new individuals into the heroin business locally, and that some time will be required before police agents can infiltrate this new underworld apparatus. It has been several years since a major heroin trafficking case has been made in this city. Further, the local drug scene has become much more complex during recent years, with the abuse of nonopiates becoming more prominent (18, 19). It is easier for police officers to make buys and arrests in cases which do not involve heroin, so officers unintentionally may be devoting a disproportionate share of their time and energy on these less important problems which are more likely to result in a good case. Police corruption is always a possibility in an area where the profits to be made are enormous, although there is no evidence to support such a possibility in this city.

Finally, some police officials have claimed that the problem really lies with the courts, which have become increasingly lenient in recent years in handling drug cases, particularly small scale dealers who, themselves, may be heroin users. Such individuals are eligible for diversion from the criminal justice system into the treatment system, and thus may remain on the streets after their arrest. There is objective support for this argument in a recent study which revealed that only 16 percent of those arrested for drug law violations and drug related crimes in the District of Columbia were actually incarcerated (20). Whatever the explanation, it is clear that an enhanced law enforcement effort will be required if local heroin availability is to be reduced to previously low levels.

Second, a most disturbing development is the observation that during a time of increased demand for heroin treatment services, the census within NTA

programs has continued to decline. There are now less than 1,600 patients actively in treatment, compared to the 4,600 patients in treatment when the program was at its peak in mid-1972. Declining census during a period of rising admission rates means that patients' retention in treatment is very short. The patient turnover is quite high. This is of great concern since the available data would suggest that duration of treatment is probably the single most important variable in determining patient outcome (21). One possible explanation for this phenomenon may be the decision to eliminate methadone take-home privileges for stabilized patients in treatment. This means that even when an addict is drug-free, employed and in a stable family situation he is required to come to the clinic 7 days a week to receive his medication. This makes treatment much less attractive for patients and is counter to the treatment goal of reintegrating the patient into the mainstream of community life as soon as possible.

Thus, patients are more likely to seek treatment when they are in trouble, and then leave as soon as they have reduced their level of dependence to a more readily managed level. Such a policy can only be a deterrent to both seeking and remaining in treatment, and should be reconsidered in light of the growing heroin problem documented here. In addition, there has been a major reduction in treatment capacity at NTA since 1973. The program, which at its peak was spending $8.0 million annually with 18 clinics and 4,200 treatment slot, currently (fiscal year 1975) is funded at $5.3 million with 3 clinics and 2,100 treatment slots. This reduction in funding, staff, and physical facilities parallel the decline in heroin abuse in Washington. While elimination of excess capacity was appropriate from the management point of view, this decline in resources devoted to drug abuse treatment has been associated with an attitudinal change within the bureauracy in which heroin is no longer seen as a problem. This institutional apathy could become critical if the current increase in prevalence of heroin use is followed by an increase in the incidence of heroin use, as it has been in Boston and San Francisco. It has been our experience that, contrary to what one might expect intuitively, demand for treatment increases during times of increased heroin availabiltiy. This may result from increased potential for adverse personal and social consequences that accompany use of heroin in higher doses. Rising property crime and heroin overdose death rates may be manifestations of this increased risk. Thus, everything possible should be done to insure that treatment is available and attractive to all those who are in need of such services.

In conclusion, data collected through a prospective drug abuse surveillance system have suggested that the rate of heroin abuse is currently rising in the District of Columbia. Rising heroin purity, increased numbers of heroin overdose deaths, increased detection of heroin positive urine specimens in the Superior Court arrestee population, increased demand for addiction treatment services, and rising property crime rates all corroborate this assertion. Similar trends have been documented in at least two other major American cities (14, 15). This increase in the prevalence of heroin use in Washington has not been associated yet with an increase in new heroin use, although increased incidence of new heroin use has been described in both Boston and San Francisco. The increase in heroin use appears to be associated with the development of a new heroin distribution system, which is supplying brown heroin (largely of Mexican origin) to areas of the country that were previously dependent upon European white heroin. The data suggest that the impact of reducing heroin availability (as seen in the east coast heroin shortage of 1972–73) may be more critical than previously suspected in helping to reduce the rates of heroin abuse to minimum levels. Continued application of both intensive law enforcement and treatment efforts will be required if society chooses to make control of heroin abuse a major goal.

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TABLE 1.—*Annual Charges Made by the D.C. Metropolitan Police for Possession and Distribution of Opiates*

Year:	*Charges*
1968	408
1969	958
1970	1588
1971	3114
1972	2108
1973	958
1974	[1] 900

[1] Projected annual total based on data complete through the third quarter of 1974.

TABLE 2.—*Annual Reported Property Crime in Washington, D.C. (Includes robbery, burglary and all larceny)*

Year:	*Total reported property crime*
1960	15,564
1961	15,982
1962	16,449
1963	19,806
1964	22,109
1965	25,343
1966	29,920
1967	41,886
1968	48,741
1969	67,209
1970	66,802
1971	56,922
1972	41,938
1973	41,873
1974 [1]	46,662

[1] Annual estimate projected on the basis of data complete through November 1974.

TABLE 3.—*Age at First Admission for Yearly NTA Admission Cohorts*

Year first admitted:	*Mean age (years)*
1970	26.0
1971	26.5
1972	25.1
1973	26.7
1974	27.7

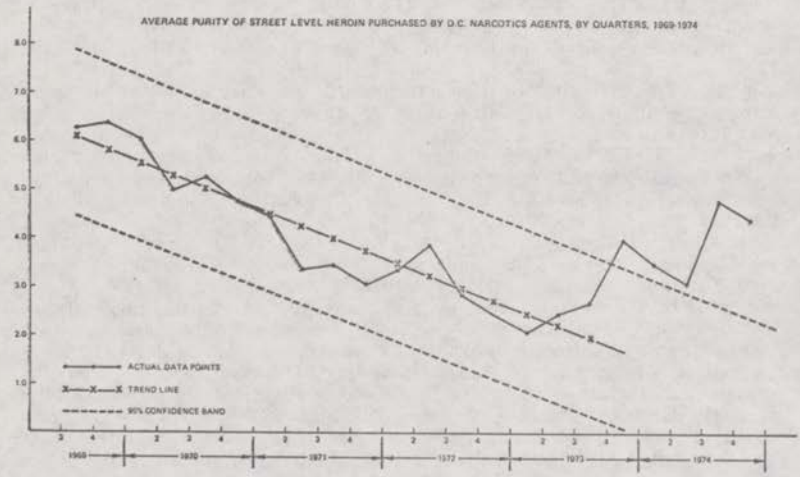


FIGURE 1

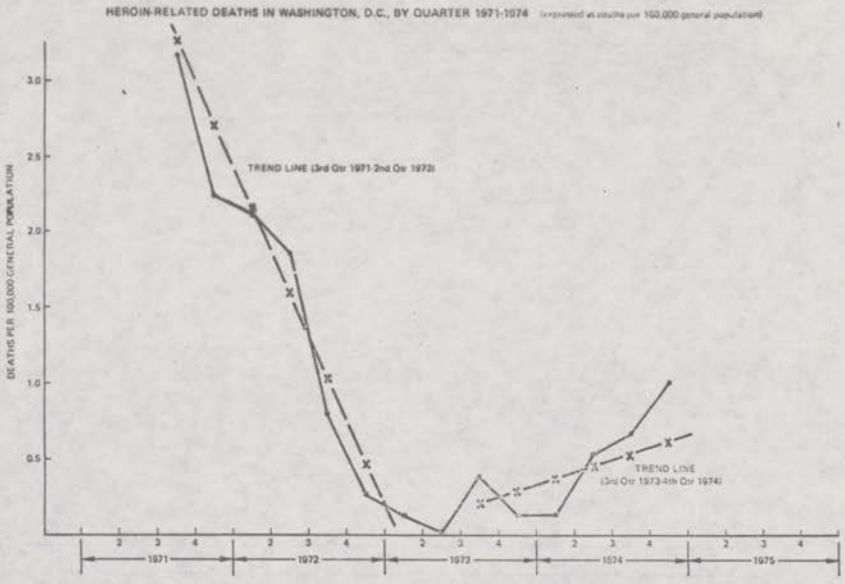


FIGURE 2

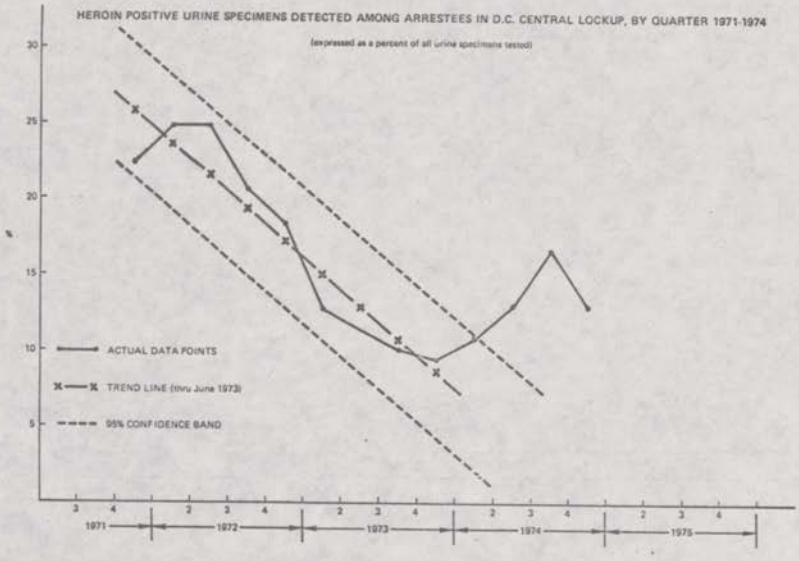


FIGURE 3

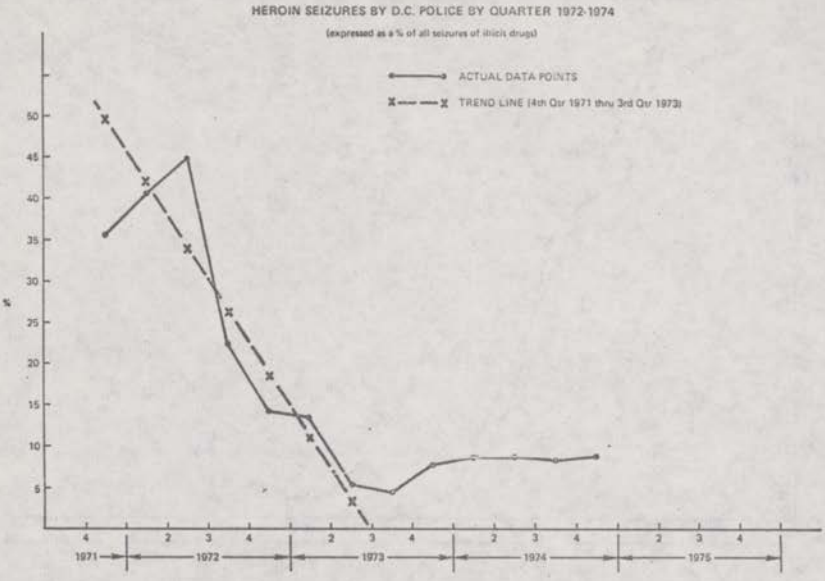


FIGURE 4

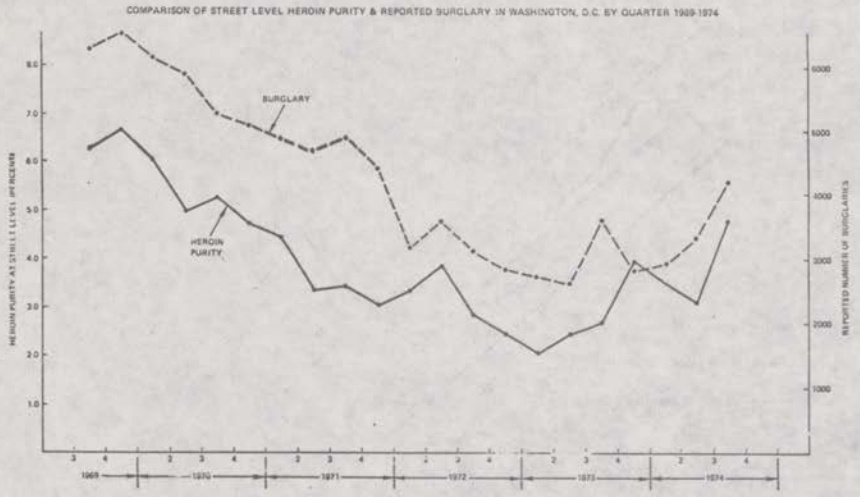


FIGURE 5

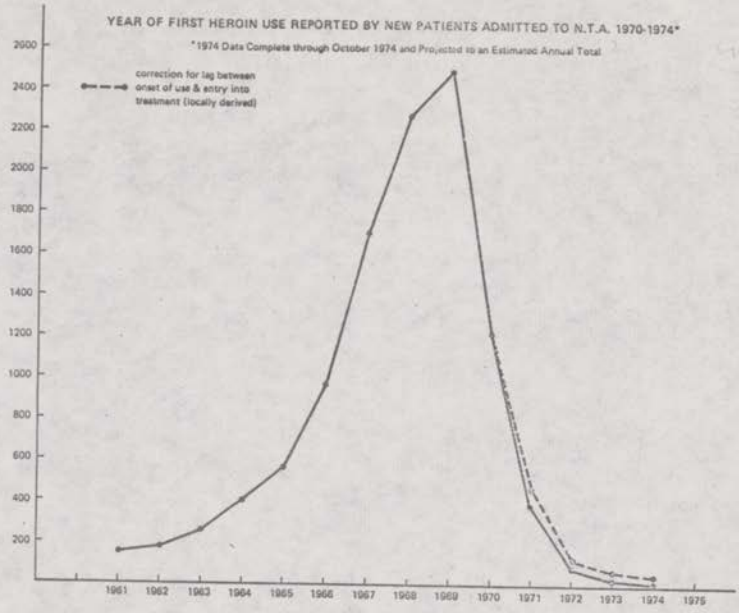


FIGURE 6

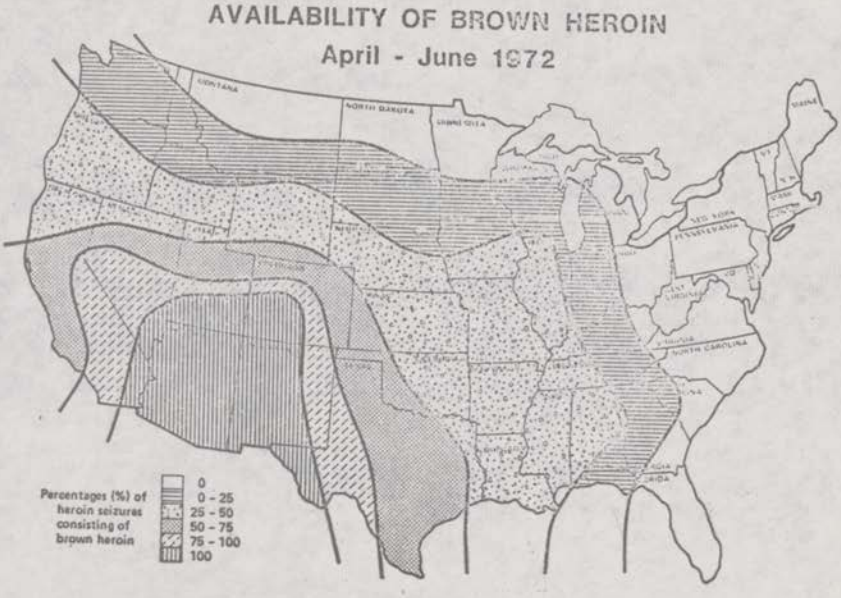


FIGURE 7A

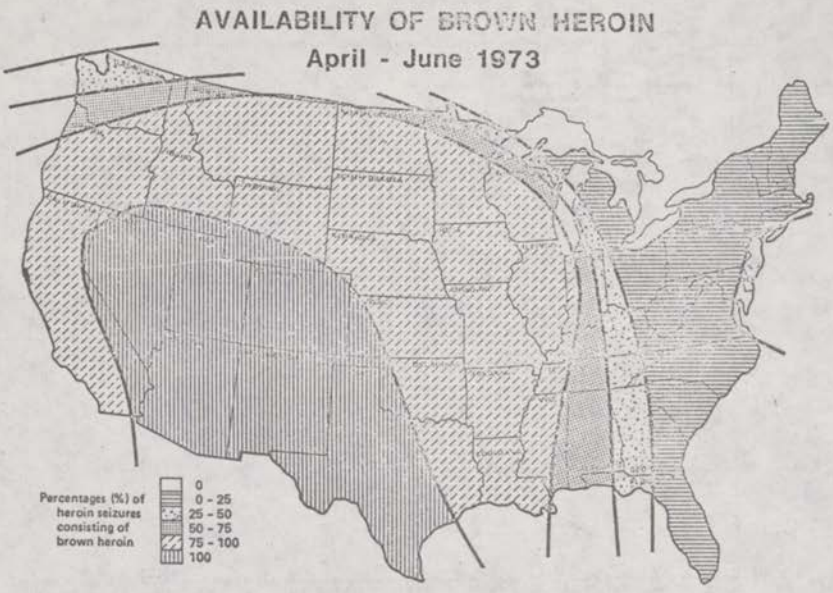


FIGURE 7B

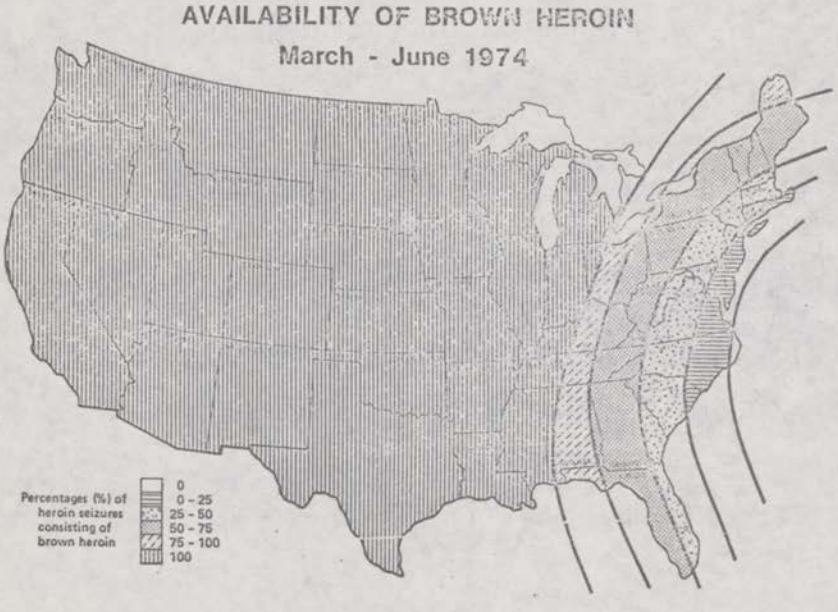


FIGURE 7C

FINDINGS IN MARIHUANA RESEARCH

Mr. CONTE. Would you provide a summary, and elaborate for the record if you like, on recent findings from marihuana research? What is the administration's position on either reducing the penalties, or decriminalizing the possession or use of marihuana?

Dr. DUPONT. A detailed summary of recent marihuana research findings through October of 1974 is to be found in the fourth edition of the "Marihuana and Health" report from the Secretary of Health, Education, and Welfare to the Congress. Still more recently there has been some additional evidence that heavy ingestion of marihuana may result in decreses in growth hormone in users. While it should be emphasized that there is as yet no clinical evidence of such adverse consequences, we are concerned that, coupled with earlier findings that levels of serum testosterone are reduced in users, this finding may have adverse implications for childhood and adolescent development. We are also concerned that marihuana use may interfere with basic cell metabolism by interfering with the production of DNA which is basic to cellular replacement and that the drug may interfere with the body's defense system which could possibly result in increased susceptability to a wide range of illnesses including cancer. While the implications of these preliminary findings are at this point speculative, they underscore the need to continue to carefully assess the health implications of cannabis use rather than to assume relative safety in the absence of immediate evidence of health hazard over relatively short term American cultural use.

The administration is not presently considering any change in Federal laws on marihuana possession and use since this is viewed primarily as an issue that should be resolved at the State and local level. However, we are pleased to see that some States are moving toward lesser penalties for marihuana possession and use and that a few States are even relegating such offenses to civil actions rather than criminal ones. The outstanding example in this instance is of course, current developments in the State of Oregon where indications are that decriminaliaztion of marihuana has not led to increased use.

COMMUNITY MENTAL HEALTH CENTER

Mr. CONTE. You said that there were 591 federally funded CMHC's. Did I understand you to say that when these 591 are operational services will be avaliable to about 41 percent of the Nation's population?

Mr. ISBISTER. There were 591 federally funded CMHC's as of June 30, 1974. By June 30, 1975, we anticipate there will be 626 funded CMHC's. When these are operational, we anticipate they will serve areas in which some 93 million people live, or 44 percent of the population.

Mr. CONTE. I believe that in the past, the administration has taken the position that this was a demonstration program which, having been proven, could be phased out. Is this still your position?

Mr. ISBISTER. The administration believes the CMHC program has demonstrated its effectiveness as a community-based mental health service delivery system. While it has taken the position that Federal

support for new starts of CMHC's should be phased out, it believes that the development of CMHC's should continue under the aegis of State and local support.

CMHC REVENUES

Mr. CONTE. I think one of the central questions about mental health centers is whether they can become self-sustaining. Do you have any evidence that they can? Please provide every hint, every scrap of evidence you have to indicate that without Federal funding the community mental health center program will continue.

Dr. BROWN. A recent survey indicated that out of 29 centers which had reached the end of their periods of Federal support, 25 managed to obtain funds from the State or community. In addition, approximately 60 percent of the centers now receiving Federal funding at the nonpoverty level report either fair or good prospects for continued support after Federal funds run out. Among those centers now receiving Federal funds at the higher "poverty funding" level, some 47 percent foresee a favorable financial future.

Mr. CONTE. I believe that third-party reimbursements have traditionally accounted for about one-fourth of mental health center revenues. Is there any indication that this might increase?

Dr. BROWN. Historically, CMHC's have been confronted by a variety of administrative and legal barriers to the fullest use of third-party reimbursements. We are now beginning to see a significant tightening up of the CMHC fiscal management, accounting, billing, and collection systems. In addition, there is a more sophisticated and careful approach being taken toward the determination of patient's eligibility status. All of this should help the level of third-party income. I would also hope that the upward trend can be accelerated by an increased technical assistance effort.

Mr. CONTE. Both the investigative staff report prepared for this committee, and the GAO report on community mental health centers, question the availability of third-party reimbursements for CMHC services. What evidence do you have that these investigators did not have?

Mr. ISBISTER. We have not received the investigative staff report, so I could not comment on the report itself. However, we do have some provisional data for 1973. These data are more recent than the material used by GAO, and show that private and voluntary insurance account for 7.9 percent of CMHC revenues; medicare pays 1.7 percent; medicaid pays 8.6 percent; and other sources account for 3.8 percent. The current trend shows medicare dollars leveling off, while medicaid and private insurance income is increasing.

Mr. CONTE. Is your reliance on third-party payments justified in light of your withdrawal of support for a national health insurance proposal?

Mr. ISBISTER. It is felt that this approach is still a viable one, if attention is given to such factors as technical assistance and working to remove the legislative and regulatory factors which now tend to inhibit the full use of third-party payments.

FEDERAL COORDINATION OF FINANCING PROGRAMS

Mr. CONTE. Has ADAMHA coordinated its activities with current Federal financing programs such as medicaid and medicare?

Mr. ISBISTER. Yes. ADAMHA/NIMH staff have been working with MSA on the development of guidelines and regulations impacting on medicaid reimbursement for mental health services and on the quality of mental health care. NIMH provides consultants to survey and certify psychiatric facilities in collaboration with the Bureau of Health Insurance based on special medicare requirements. NIMH has an ongoing, liaison program involving both the Bureau of Health Insurance and the Medical Services Administration, entailing monthly meetings to exchange information about current issues. These are just a few of the liaison activities engaged in by ADAMHA staff with medicaid and medicare staffs.

CMHC FUNDING AND TITLES 4 AND 6

Mr. CONTE. I understand that there was a February 6 departmental ruling requiring CMHC's to deduct Federal categorical grant funds before calculating the costs of services to be reimbursed under titles 4 and 6 of the Social Security Act. How does this fit in with attempts to maximize third-party payments? How will this affect reimbursement procedures under medicare and medicaid?

Mr. ISBISTER. This decision does not change DHEW policy in this area, but merely reaffirms what SRS had already stated as its policy a year or more ago. The decision will reduce funds available for CMHC's, but CMHC's in most States have not relied heavily on such funds. In some States, for example, Kentucky and Florida, where a substantial amount of funds have been received by CMHC's from title IV–A, the decision will have more major effects. The decision by itself, however, should not affect reimbursement procedures under medicare and medicaid, since it is specifically limited to title IV–A.

STATE AND LOCAL FINANCIAL SUPPORT

Mr. CONTE. Do you really believe that State and local governments have the excess resources to make up for the loss of Federal support in light of the current economic situation?

Mr. ISBISTER. State and local governments are indeed experiencing financial difficulties as a result of the current decline in economic activity and a resulting decline in tax revenues. The Federal Government, however, is also facing severe budget deficits which are unprecedented in the past couple of decades.

ADMINISTRATION OF CMHC PROGRAM

Mr. CONTE. The investigative staff report on the community mental health centers program cites numerous organizational problems with the administration of this program. Two of these are particularly disconcerting—confusion over the authority of the regional and central offices, and inadequate staffing in the regional offices. As background, could you summarize, and elaborate for the record, if you want to, on the roles of the various central office components and the regional offices in administering the CMHC program?

Dr. BROWN. Basically, the community mental health centers program is decentralized with review and approval authority and responsibility for day-to-day monitoring of programs vested in the regional offices. The development of policy, program guidelines, budgetary data and program information is vested in central office, along with the responsibility for national oversight of the program. The regional offices are not under the jurisdiction of NIMH.

Mr. CONTE. What efforts are you making to improve the regional capability to carry out the objectives of the CMHC program?

Dr. BROWN. The NIMH has been working closely with the regions to improve their capacity for carrying out the objectives of the CMHC program. In addition to providing consultation and technical assistance to the regions, NIMH staff meets regularly with the regions to discuss problems and issues in administration of the CMHC program. To promote more effective site visiting, the NIMH has developed a site visit protocol that will provide a more uniform standard for the regional offices and a series of training sessions have been undertaken by NIMH.

Mr. CONTE. Do you have adequate regional staff to effectively administer the program at the regional level?

Mr. ISBISTER. The regional staff is under the administrative control of the regional health administrator. The regional health administrator's work plans submitted by the regions indicate that monitoring and consultation is often inadequate to assure quality programs.

Mr. CONTE. What actions have been taken, and what do you intend to do, to improve regional and central office coordination of this program?

Mr. ISBISTER. ADAMHA and NIMH have involved regional offices in identifying communication and coordination problems and surfacing policy and programmatic issues affecting the conduct and administration of the CMHC programs and initiated action, whenever possible to deal with these problems. This has been accomplished by holding regularly scheduled meetings with ADAMHA branch chiefs and regional office mental health program consultants, conducting site visits to the regional offices, and inviting the participation of regional office staff in joint planning committees.

POSITIONS FOR CMHC PROGRAM

Mr. CONTE. How many people in the regional offices are assigned to the administration of the CMHC program? How many in the central office? Would the program be better administered if you had more positions? How many more would be needed?

Mr. ISBISTER. There are approximately 100 positions in the regonal offices and 18 people in the central office assigned to the administration of the CMHC program. There is no doubt that if additional positions were available, the program could be more effectively administered. We estimate that approximately 26 new positions would be needed in the regional offices and 11 new positions would be needed in the central office to manage the program under existing legislation.

CMHCS AND MINORITY GROUPS

Mr. CONTE. Can you tell me what portion of the CMHC program provides significant minority group service, that is for Blacks, Indians, Spanish speaking, and Asian Pacific people? Do you have any statistics on the incidence of alcoholism and mental illness in these minority groups, relative to the population as a whole?

Mr. ISBISTER. I would like Dr. Brown and Dr. Chafetz to comment on this.

Dr. BROWN. A study in 1972 indicated that 82 percent of the admissions to 194 CMHC's were white and 18 percent nonwhite. The rate of admissions for nonwhites was higher than the rate for whites. While our data does not currently differentiate by ethnic background, CMHC's are required to provide services to meet the needs of all catchment area residents, including minorities. With regard to services for Indians, for example, NIMH has funded 48 CMHC's to serve a total of 59 reservations.

Accurate statistics on the incidence and prevalence of mental disorders in minority populations are difficult to arrive at. Nonetheless, we are aware that minority populations experience the same range of problems as the general population and certain problems such as alcoholism and drug addiction, in certain instances, may be more pronounced among some minority groups.

Dr. CHAFETZ. Information gathered to date indicates that the incidence of alcohol problems among blacks and whites is about equal—12 percent of the population.

American Indians, however, have a rate of alcoholism that is estimated to be at least two times the national average, and on many reservations from 25 to 50 percent of the population.

Furthermore, the alcoholism death rate for the Indian and the Alaskan Native population ranges from four to five times that of the general population. No figures exist to date for Asian Americans or Spanish Americans.

MANAGEMENT PROBLEMS IN TRAINING PROGRAMS

Mr. CONTE. Dr. Brown, what problems have you and your staff had in the review and management of your mental health training programs during the current fiscal year? Do you anticipate any such problems in fiscal year 1976?

Dr. BROWN. The mental health manpower and training programs have represented over many years a serious commitment at the Federal level to the development and enlargement of the Nation's resources for addressing our mental health needs and concerns. For fiscal year 1975, in sheer volume alone, these programs represent over 1,600 individual projects, $94.6 million, 6,000 students in training and a minimal Federal contribution of varying degrees toward maintaining viability of the many institutions and agencies throughout the programs have been proposed annually for phaseout, but through expression of congressional concern, have been maintained.

Perhaps our most serious problem, and our gravest concern, has been to assure the most responsible and the most effective utilization of the

funds made available very belatedly each year in the appropriation and in the context of this annual uncertainty. In addition, we are very conscious of our responsibilities as Federal mental health officials, to provide appropriate and timely assistance to applicants and recipients of Federal support, and to keep them apprised of prevailing national policies on its receipt.

Our special problems for fiscal year 1975, and those we anticipate for fiscal year 1976, arise from several inflexible aspects of administering a complex competitive grants program. First, normally 18 months prior to the close of a fiscal year, and no less than 9 months, the field should be advised through a general announcement of the general conditions and policies of prevailing for the receipt and competitive review of grant applications. Second, a receipt deadline for competitive applications, ideally the September prior to the termination of the fiscal year, should be confirmed as part of this announcement. Third, approval should be given for the establishment of initial review groups, allowing for their formal chartering and the appointment of their memberships by the fall, to assure a responsible and meritorious site visit and review process for all applications. Finally, timely resolution of all major budget issues related to the award and utilization of the appropriated funds is essential.

Few, if any, of these conditions prevailed for fiscal year 1975. As a result, very belated but heroic efforts had to be undertaken in the last portion of the fiscal year so that funds provided by the Congress could be obligated in a timely and responsible manner consistent with previous standards of professionally sound and meritorious review.

MENTAL HEALTH MANPOWER NEEDS

Mr. CONTE. Dr. Brown, are there currently enough mental-health workers? Do you have any projections on mental-health manpower needs over the next 5 years? What kinds of assumptions are you using in making those projections?

Dr. BROWN. There are currently about 200,000 mental-health workers in the Nation, divided evenly between professionals and subprofessionals of various disciplines. We are currently concentrating on the latter group, using them as extenders of the professionals—both in the provision of mental health care and of outreach services. Are there enough workers now? In a very minimal sense, yes—although there is a problem of maldistribution. Roughly 2½ percent of our population is using their services, and this 2½ percent represents persons with major or serious problems. In 5 years, we estimate that we will have a shortage of approximately 37,000 professionals in the core disciplines of psychiatry, psychology, nursing, and social work alone. This projection is based on conservative criteria. In developing the estimate, we assumed only a minor increase in demand associated with some form of national health insurance, and some expansion in the number of community mental health centers. In short, we are assuming a utilization rate which would increase to only 3½ percent, and even this has been plotted against a zero population growth. If you break out the shortage by profession, it would come to 9,400 psychiatrists, 8,500 psychologists, 7,150 social workers, and 12,200 psychiatric nurses.

Mr. CONTE. What would be the effect of a national health insurance program on these mental health manpower needs?

Dr. BROWN. An NHI program offering the most modest mental-health benefits will increase the demand for and the utilization rate of mental-health services. Our manpower projections reflect only a very conservative increase in the utilization rate, from 2½ percent to 3½ percent, as a result of NHI. On this basis there is already a projected deficit of over 37,000 mental-health professionals by 1981. Should an NHI program provide more generous benefits, or if a more realistic utilization rate is assumed, this deficit in supply over estimated demand would worsen significantly.

Mr. CONTE. Do you believe that we will be able to meet these manpower needs if all of your training programs are phased out?

Dr. BROWN. The Federal investment in mental-health training represents a significant contribution in the development of the total mental-health manpower pool. Our manpower projections through 1981 reflect significant deficits in the manpower pool even if States and localities maintain their present investment, and if these Federal programs are maintained at the fiscal year 1974 level of support. If the Federal effort were to be phased out, States and localities, which already provide more support for the training of mental-health manpower than does the Federal Government, would have to pick up this additional burden. The problem for the States and localities would be gravely aggravated by any increased demands on their systems for any mental-health care offered by an NHI program, and by an increased utilization rate for these services.

PREVALENCE OF MENTAL ILLNESS

Mr. CONTE. During last year's hearings, you estimated that about 10 percent of the Nation's population suffered from some form of mental illness, and that this was probably an underestimate. Would these estimates still hold true?

Dr. BROWN. Yes; the data that Dr. Egeberg provided to the subcommittee, shown on pages 393–397, part 3, of the hearings on the 1975 budget, represent the latest and best estimates we have on the scope of mental-health problems in this country.

Mr. CONTE. If they do, can you explain why there is only continuation funding, at best, and significant cutbacks in many of our mental-health programs?

Dr. BROWN. We recognize the continuing need for strong mental-health programs. The budget reflects what the administration feels is a responsible Federal effort, given the present economic situation and the many competing demands for Federal resources. The community mental health centers program will continue to support existing centers, with the Federal share reduced according to legislative formula. Upon termination of Federal support, our information indicates that virtually all centers will continue with support from other sources. It is proposed that new centers, where needed, be initiated with non-Federal funds. Mental-health training programs have had special Federal support since 1947. It is felt that they have developed to the point where special Federal subsidies are no longer required. Future Federal efforts will focus on assisting States to assess manpower needs

and develop appropriate programs and on particularly innovative demonstration efforts. In research, the budget proposes a research grants program of $50.4 million, a sizable effort in the present economic situation.

MENTAL HEALTH RESEARCH FUNDING

Mr. CONTE. Where will the money for mental-health research come from if we accept your proposal for no new research projects?

Dr. BROWN. We recognize that resources for mental-health research in the private sector and at State and local levels of government are limited. In a more favorable economic climate, a more aggressive research effort would be indicated. Maintaining an ongoing extramural research effort at $50.4 million represents, we feel, a sizable and responsible commitment to mental-health research in the present situation.

FEDERAL ROLE IN MENTAL HEALTH EFFORTS

Mr. CONTE. Are you proposing a complete elimination of the Federal effort in mental health over the next several years by supporting no new projects? What do you see as the long-term Federal role in mental health?

Mr. ISBISTER. No, Mr. Conte; we are not proposing a complete elimination of Federal mental health efforts. However, we do see a changing Federal role. In the area of mental health services, we see a move away from direct Federal subsidy of services and greater reliance on third-party financing mechanisms. A continuing Federal role will be the focusing on support of nationally significant demonstration and model programs on which the State and local sectors can draw. We would also envision an expansion of research on more effective an innovative ways of delivering mental health services; and on an expanded technical assistance program, particularly as related to the planning and financing of manpower and service programs. There would be organized efforts to develop quality assurance and cost containment measures; and on an expanded effort to work with States, at their request, to develop more effective statewide integrated systems of mental-health care. Within the constraints of a responsible Federal budget, we see a continuing Federal leadership role in developing new mental-health knowledge through research.

Mr. CONTE. The investigative staff report prepared for this committee stated that ". . . real breakthroughs in curbing the incidence of hardcore mental illness (for example, schizophrenia) will only come through more effective and increased clinical research into the causes and prevention of mental illness." But I see in your justification that there are no funds proposed for new mental illness research projects. Is it your opinion that such research is no longer necessary? Is there anything to replace Federal funding in this field?

Dr. BROWN. NIMH places the highest priority on both basic and clinical research focused on the severe mental illnesses. Particularly, focused program efforts have been mobilized on schizophrenia and depression. On schizophrenia, research on genetic factors in schizophrenia show special promise. On the depressive illnesses, psychobiological studies and studies on new psychotherapeutic approaches, and research on the use of specific biochemical markers of therapeutic response are to be emphasized.

The NIMH clinical research grants program will be maintained at a level of $8.3 million in fiscal year 1976 and that on psychopharmacology at $9.4 million. We recognize both the central Federal role in support of mental health research and that the fiscal year 1976 budget, in terms of new awards, is not good. It does continue work already underway, however, and, with the necessity of controlling the Federal budget and meeting many competing needs, we think it is responsible.

REGULATIONS FOR CMHCS

Mr. CONTE. That same investigative staff report indicated that the Federal regulations for the community mental health centers program were both outdated and inefficient. Would you agree, and is anything being done to rework these regulations?

Dr. BROWN. In February 1972 a completely revised set of regulations was published for rulemaking purposes; these, however, were never published in final form. We are currently in the process of addressing a range of issues appropriate for promulgation in revised regulations. It is important to point out, however, that regulations are only one dimension of program management and accountability. In addition to regulations, the NIMH regularly publishes policy statements and program guidelines which clarify, refine, and extend existing regulations and which are responsive to changing program needs.

CUTBACKS IN ALCOHOL STATE FORMULA GRANTS

Mr. CONTE. You have proposed a $6.4 million cutback in the formula grants to States for alcoholism program. Will the States be able to replace Federal cutbacks in the alcoholism research, training, and community programs and at the same time make up for the loss of formula grant support?

Dr. CHAFETZ. We do not anticipate that increased State and local resources will offset the 1976 reductions to a significant degree. Our public information efforts have increased the Nation's awareness of alcoholism as a critical public health problem. This factor, along with our many efforts to develop working relationships with the governmental bodies and professional organizations at the State and local levels, have greatly strengthened the overall alcoholism effort in this country. However, from the standpoint of the economy, we are all in the same ball game and share the same problem of availability of hard dollars. In the treatment area, we can see progress toward the inclusion by private insurance carriers of provisions for alcoholism services. The passage of national health insurance, with adequate coverage for outpatient and inpatient alcoholism services, would have great impact for individuals seeking treatment and for localities striving to increase their capacity for providing services. In the area of research, a federally supported program seems to be the primary discernible means of financing these activities on a national scale.

The phaseout of training in fiscal year 1976 stems from the administration's position that these activities are not an appropriate Federal responsibility. We are attempting to stimulate greater participation for manpower development at the local levels through the education of policymakers by the National Center for Alcohol Education, and through the assessment of local manpower needs conducted by the area alcoholism education and training programs.

CUTBACK IN MENTAL HEALTH STAFF

Mr. CONTE. Dr. Brown, it appears from the justification that there is a 97 position cutback proposed for NIMH. Is that true, and if so, could you explain that?

Dr. BROWN. It is true, Mr. Conte. It is felt that the staff would not be required if the training grants and community mental health centers programs were phased out. In addition, or possibly as a corollary to the staff reduction, our 1976 management and information budget would not be adequate to support the 97 positions.

Mr. CONTE. How does the number of positions stated for NIMH in 1976 compare to the 1974 number?

Dr. BROWN. In 1974, NIMH had 920 budgeted positions. The comparable figure for 1976 is 766, or a reduction of 154 positions, along with related support funds.

ALCOHOL ABUSE AND VIOLENT CRIME

Mr. CONTE. There have been newspaper articles recently about the links between alcohol abuse and violent crime. Does the increase in juvenile alcohol abuse mean that we are going to have an increasing problem with violent crime also? Can you tell me about his linkage?

Mr. ISBISTER. Let me direct that question to Dr. Brown and Dr. Chafetz.

Dr. BROWN. While the exact nature of the relationship linking alcohol and crime is poorly understood, the National Commission on the Causes and Prevention of Violence estimated that at least one-fourth of the violent crimes are alcohol related. Because of the absence of firm evidence, it is not possible to indicate the extent to which an increase in alcohol abuse by juveniles would result in an increase in violent crime. This important and complex issue obviously requires further investigation.

Dr. CHAFETZ. Teenage alcohol use and certain crimes have been commonplace over the years, for example, drinking while driving, vandalism, and a variety of nuisance crimes. An increase in abusive alcohol usage by juveniles does not necessarily mean there will be an increase in violent crimes, but there is always a possibility of this happening. Alcohol, a cerebral depressant, tends to lower the inhibitions an individual may have, thus he may do things which he might not do while sober. The majority of serious crimes, murder and rape, occur between people who know each other and these crimes sometimes occur when one or both parties are under the influence of alcohol. The pent-up frustrations in youth may be released when alcohol becomes a factor, with resultant violent crimes being committed.

In all, I feel it could be stated that increases in alcohol abuse among teenagers and others could result in an increase in violent crimes; but there are usually a preponderance of other factors involved, and frequently alcohol use does not play the most significant part.

BUDGET ASSUMPTIONS AND CONTINUATION COSTS

Mr. CONTE. I believe that this budget was prepared based upon the assumption that the rescissions would be approved. Is that correct?

Mr. ISBISTER. Yes. This is correct.

Mr. CONTE. What does the obligation of those funds which were proposed for rescission do to your 1976 continuation costs for research grants, training grants, and predoctoral fellowships? Where will you get the money for these continuation costs?

Mr. ISBISTER. Let me respond to each of those categories separately. We will be able to fund all NIMH and NIDA research grants at their full level. Unlike NIH, we have decided to reduce the level of new awards to fund continuation grants at their full level. Our first priority is to existing grantees. The only exception is the NIAAA research grants. After utilizing all funds previously available for competing awards, we will still have a shortfall of $786,000.

With respect to training grants, each Institute will be unable to fund continuation grants at their committed level of support. The shortages are as follows: NIMH–$32.8 million; NIDA–$3.9 million; NIAAA–$5.6 million. Each Institute will honor all commitments for student support. Institutional support will be reduced by whatever amount is necessary to operate within the existing budget.

Finally, all fellowships will be awarded at their full level of committed support.

Mr. CONTE. Thank you.

Mr. FLOOD. My colleague, Mr. Shriver has submitted questions which he wishes to have answered and inserted in the record.

Mr. ISBISTER. We will be happy to do so.

(The questions and answers follow:)

COMMUNITY MENTAL HEALTH CENTERS

Question. Your budget estimate indicates that 626 CMHC's have been funded since 1966. Will you please furnish the committee with a list of these Centers, indicating the kinds and amounts of grants each has received?

Answer. I will be happy to do that. Mr. Shriver. However, because of the considerable length of the material, I would like to transmit the data to the committee under separate cover, rather than attempt to insert it into the record. The data includes the 591 CMHC's already funded. The additional 35 centers anticipated to be funded this year is unknown at this time.

Question. Your statement also states that 150 CMHC's have been established without Federal funds. Will you please furnish the committee with a list of those centers, along with an indication as to how each of them was financed? Will you please, also, advise the committee as to how you defined a CMHC in arriving at this statistic?

Answer. I will be glad to. However, because of the considerable length of the material. I would like to transmit to the committee under separate cover a list of 183 facilities which provide at least four of the basic services required of CMHC's, rather than attempt to insert it into the record. While these facilities are not directly equivalent to CMHC's, they do provide a rescource base on which to build a comprehensive coordinated network of community care. Many of these facilities are financially supported by State or local government.

[CLERKS NOTE: The materials referred to above have been received by the committee.]

EXPLANATION OF HEROIN INCREASE

Mr. FLOOD. Mr. Smith?

Mr. SMITH. I don't believe you explained what you believe to be the reason why drug abuse apparently went down for a year and is on the rise again.

Mr. ISBISTER. I think it had to do with the combined two national efforts, one to reduce the supply of the materials coming into the country, and, as Dr. DuPont has indicated, once the supply was cut off from Turkey, it began to pop up other places around the country.

Another reason for the increase has been that we have noted through several studies that the problem has been spreading geographically, so it is no longer a central city problem. The problem is now arising not only in the suburbs but in small towns.

Dr. DuPont might want to elaborate.

Mr. SMITH. You mean, then, the supply actually reduced for a year and then the supply is increasing again; is that right?

Dr. DUPONT. Yes, sir.

REGIONAL OFFICES

Mr. SMITH. You are set up with regional offices. You have offices in the HEW regional office?

Mr. ISBISTER. We don't have our own offices in the regional offices. The Department has the 10 regional offices and in 9 of the 10 regional offices there is a separately identified branch that is called the Alcohol, Drug Abuse, and Mental Health Branch. In the tenth one there is not a separately identified branch.

Mr. SMITH. Why is it different in the tenth?

Mr. ISBISTER. They allowed each one of the regions, at least at the branch level, to determine what form of organization they would have. In the Atlanta region they elected a different, more functional form rather than a category form of organization, as did initially the regional office in Philadelphia. They have changed however, and are creating a branch.

But the staff there do not report to us; they report through the Regional Health Administrator to the Assistant Secretary for Health.

POSITION ALLOCATIONS

Mr. SMITH. What is your total number of permanent positions, then, altogether?

Mr. ISBISTER. We have 1,590.

Mr. SMITH. That is for 1976 estimated?

Mr. ISBISTER. Yes, sir.

Mr. SMITH. How many do you have on board at the present time?

Mr. ISBISTER. On March 29, 1975 we had 1,591.

Mr. SMITH. That is more than you were authorized.

Mr. ISBISTER. No, that is for this fiscal year and includes 10 positions for the Working Capital Fund which are authorized under another appropriation. Also the authorization for the number of budgeted positions in the 1975 budget is greater than 1976. We are authorized 1,696 in fiscal year 1975.

Mr. SMITH. Okay. How many of those as of March 29—I believe you said, 1,591—were in the Washington area, and how many in the regional offices?

Mr. ISBISTER. There are 118 in the regional offices, and then we have the Addiction Research Center in Lexington, Ky., which is also out of the Washington area, and that has 102. The remainder are all in the Washington area. The figures I am giving you are exclusive of St. Elizabeths Hospital, but we do have research programs at St. Elizabeths Hospital. We have research programs on the grounds of the National Institute of Health, and we have our administrative offices in Rockville.

CONTEMPLATED REORGANIZATIONS

Mr. SMITH. What shift are you contemplating in your table of organization?

Mr. ISBISTER. Having just gone through the trauma of an extended reorganization period and process which created this agency, we are anticipating no major shifts in our table of organization.

Mr. SMITH. Have you been doing some shifting in the past year?

Mr. ISBISTER. Well, the creation of this agency occurred in the late fall of 1973, and it led to the creation of the three institutes and my office, and we have made only minor adjustments since that time.

Dr. Chafetz, within the Alcoholism Institute, however, is considering some reorganizations within his institute.

REORGANIZATION IN THE ALCOHOL INSTITUTE

Dr. CHAFETZ. If I may, Mr. Smith, the issue of our examination of the new priorities within the institute has of necessity, in our opinion, an examination of the total structure of the institute that is now 4 years old, and we are contemplating within the National Institute on Alcoholism Abuse and Alcoholism a major reorganization to respond to what our new needs, such as women, young people, the aged, and a variety of situations like that, so we may be engaged within the institute in a major reorganization in the foreseeable future.

Mr. SMITH. What kind of form would that reorganization take?

Dr. CHAFETZ. Well, I think it is very early to tell you, and I would not want to lock myself in, but we have had a task force within the institute getting input from the outside constituencies who have been advising us how we might reorganize with our small complement into a new approach to respond to the new needs we have recognized among alcoholic people in this country.

GRADE LEVEL INCREASES

Mr. SMITH. In your proposal you are proposing an increase in the average GS grade level from 7.85 to 9.80. That is a pretty substantial increase for 1 year. Where are those going to be allotted, these increases, and how do you get that big an increase in 1 year?

Mr. ISBISTER. The reason for that, Mr. Smith, is that St. Elizabeths Hospital comes out of the calculation in the 1976 increment since the hospital is proposed for transfer and, on the average, the grade level at St. Elizabeths Hospital is much lower than for the rest of the organization. They also have the largest number of positions.

St. Elizabeths Hospital, I am told, is in the one calculation but not the other one.

Mr. SMITH. St. Elizabeths is in the 1,591?

Mr. ISBISTER. No, sir, as I indicated earlier, it is not in the 1,591. St. Elizabeths has a budgeted position level of 4,028.

Mr. SMITH. It is not in the increase of 9.80 either, but I am looking at your estimate of 1,590 permanent positions, and that is where at St. Elizabeths, in addition to 1,590 positions, this is another increase?

Mr. ISBISTER. We will have to check that carefully. It could be an error. I can't imagine our average grade has gone up by anywhere near that amount.

Mr. MILLER. Are you looking at the increase in the new positions?

Mr. ISBISTER. He is looking at the average grade level.

Mr. SMITH. I don't think it is an error because the average salary level increases too.

Mr. ISBISTER. It is from 7.8 to 9.8.

Mr. MILLER. The whole issue is whether St. Elizabeths is in both sides of the equation or not. If it is not, our explanation is right; if it is, we will have to provide you an explanation.

Mr. SMITH. The total number of positions 1,590, going back to the earlier questions, must be exclusive. The number of dollars increases accordingly. So it makes me wonder.

Mr. LEONE. The average salary is a reflection of the increased agency grade level resulting from the proposed transfer of St. Elizabeths Hospital.

Mr. SMITH. The average GS grade salary increases from $13,048 to $15,837, and that would be about two grade levels.

Mr. LEONE. The explanation Mr. Miller stated is right. The figures for GS grades and GS salary includes St. Elizabeths in 1975 but excludes St. Elizabeths in 1976 because of the proposed transfer of the hospital to the District of Columbia.

Mr. SMITH. Then how do you account for the first figure above, the number of permanent positions, and they are not included?

Mr. LEONE. That is the inconsistency. The number of permanent positions excludes the hospital in both years, since it reflects only those positions in the "alcohol, drug abuse, and mental health" appropriation. The average number grade figures are calculated on a total agency basis and include the hospital in 1975 but excludes them in 1976 because of the proposed tarnsfer.

Mr. SMITH. Are you saying the average grade level or the average salary level will be the same in 1976 as 1975, excluding St. Elizabeths?

Mr. LEONE. Essentially the same; yes, sir.

Mr. SMITH. Haven't you been reducing the grade levels in some of the regional offices?

Mr. ISBISTER. None of the grade levels have been reduced for any of our regional office positions. There have been some studies underway in the Philadelphia regional office and most recently in Atlanta, which are proposing, after the Civil Service Commission reviews, that some of the grade levels should be considered for reduction, but a final decision on that hasn't been made.

Mr. SMITH. This downgrading then is not included in your proposal?

Mr. ISBISTER. No.

Mr. SMITH. There hasn't been a final decision. Is that correct?

Mr. ISBISTER. That is correct.

Mr. MILLER. I think there is one thing, Mr. Smith, on the regional offices, that didn't come through quite clearly, that needs to be part of the record. Mr. Isbister was describing the alcohol, drug abuse, and mental health component of the regional office. There is a major health organization in each HEW regional office. But the health programs which have most decentralized activities are probably the health services and the health resources programs.

Mr. SMITH. What is the average grade level at St. Elizabeths?

Dr. BROWN. That is the next item. It is 7.1.

Mr. SMITH. It is proposed to raise it to what?

Dr. BROWN. Approximately the same, as far as I know, Mr. Smith.

Mr. SMITH. Then we still don't have an explanation. I can't take 7.1 and average it with 7.8 and get 9.8.

Mr. MILLER. If the percentage of employees at St. Elizabeths is a really major percentage of the total, you could.

Mr. ISBISTER. It is 4,000 out of 5,700, so it would have that effect. It is roughly 4,000 out of 5,700 of our employees are at St. Elizabeths Hospital.

Mr. FLOOD. Then you raise them from 7.1 to what?

Mr. LEONE. Their average isn't being raised. When we exclude them from our classifications the average grade for the rest of the agency is about 2 points higher than St. Elizabeths Hospital.

Mr. MILLER. If you have 4,000 employees with an average grade of say 7 in one side of the equation and you take all of those employees out and they are not computed in the other side of the equation, it is going to raise the other side of the equation quite significantly.

Mr. SMITH. But they are not increasing the grade level on the 4,000. You have to increase somebody's grade level or you can't get an increase.

Mr. ISBISTER. The average grade level for the other 1,600 positions is 9.8.

Mr. SMITH. Right.

Mr. ISBISTER. For the 4,000 it is 7.0. In that table in 1975 when they were both included where the average grades then came out to 7.85. Since St. Elizabeths was excluded in fiscal 1976 it is only the 9.8 average grade in relationship to the 1,600 positions.

Mr. SMITH. So how much are you increasing them at St. Elizabeths?

Mr. ISBISTER. We are not.

Mr. SMITH. You are not?

Mr. ISBISTER. We are not increasing the average grade to any significant amount in either side of the equation. St. Elizabeths will remain about 7.1 and we will remain about 9.8.

Mr. SMITH. You have kind of a hybrid table there.

Mr. ISBISTER. Yes, sir. The table is inconsistent and the figures for permanent positions and average grade and salary are not comparable. The permanent positions were listed in the table on an appropriation basis while the average grade and salary for 74 and 75 were calculated according to the overall ADAMHA agency and therefore included St. Elizabeths Hospital personnel. St. Elizabeths was excluded from the ADAMHA budget and the agency calculations for average grade and salary in 1976 because of the proposed transfer of the hospital. The average grade at St. Elizabeths has remained steady at 7.0 and the ADAMHA average grade has remained level at 9.8. Since St. Elizabeths currently represents almost 80 percent of the total number of positions in the agency, the removal in 1976 of the hospital personnel from the calculation of the average grade makes it appear that the average grade of ADAMHA personnel has jumped up almost two grade levels.

Mr. SMITH. That is all, Mr. Chairman.

Mr. FLOOD. Mr. Patten.

Mr. PATTEN. Thank you, Mr. Chairman.

With the severe budget cuts requested by the President could you tell us how many psychiatric nurse trainingships you plan for 1976 and how this figure compares with those of the last 2 years? And break it down in the graduate and undergraduate students.

NIMH STIPEND AWARDS TO PSYCHIATRIC NURSES

	Level of training		
	Undergraduate	Graduate	Total
Fiscal year:			
1974	198	1,112	1,310
1975	157	962	1,119
1976	72	618	690

Mr. PATTEN. If we take somebody into a hospital, whether drunk or not, they don't like to admit patients difficult to control. The hospital feels it is not equipped to handle mental problems. If we have more trainees in psychiatric nursing we could help these difficult patients. They tell me they are short of nurses with psychiatric training.

Mr. ISBISTER. We will be supporting, during fiscal year 1975, Mr. Patten, the training of 1,119 psychiatric nurses. And in fiscal year 1976, as a result of the phaseout of this program—we are not going to be bringing any new students into the program under this proposal—we would support 690. They would be students who have already begun the program in fiscal year 1975.

ALCOHOL AND HIGHWAY FATALITIES

Mr. PATTEN. You read time and again in papers three young kids hit a pole at 2 a.m. Statistically I think we have killed in recent years as high as 57,000 people by the automobile. What factor does alcohol play in these deaths?

Mr. ISBISTER. Very substantial, and Dr. Chafetz has a fairly accurate estimate of that.

Dr. CHAFETZ. It will not be a guess, Mr. Patten. Of all of the traffic fatalities, 40 percent are alcohol related to heavy use. But what is of greater concern to us is the fact that if you just take the age group between 16 and 24 it jumps to 60 percent of all fatalities on the highway are alcohol related.

Mr. PATTEN. That is why the insurance companies want to know if I have anyone under 25 drive my car.

Mr. CHAFETZ. They charge you more because they are inexperienced drivers and inexperienced drinkers, and when you mix the two together you have the kind of horrible statistics we have.

Mr. FLOOD. Mr. Roybal.

EFFORTS TO RESTRICT HEROIN DISTRIBUTION

Mr. ROYBAL. Thank you, Mr. Chairman.

I was interested in the statement that was made a little while ago to the effect that this Government is pleased with the efforts of the Mexican officials to reduce the flow of narcotics into the United States. I am very curious. What is the effort of the Mexican government?

Dr. DUPONT. They have a major program, Mr. Roybal, aimed at eradicating poppy cultivation in broad regions in the mountainous parts of Western Mexico. The Mexican Army is involved in this effort. They have also mounted major law enforcement efforts aimed at identifying clandestine laboratories and interrupting the illicit distribution chain at all points.

These efforts are very closely integrated with our drug enforcement administration's own initiatives effort to reduce the flow of Mexican heroin into this country.

Mr. ROYBAL. Where does the failure then take place? The narcotics continue to come into the United States and seem to come from Mexico.

Dr. DUPONT. Yes, sir.

Mr. ROYBAL. If their program is so effective, why do we continue to get more drugs?

Dr. DUPONT. There is a tremendous economic inducement to produce heroin. For this reason, the illicit manufacturers in Mexico go to considerable lengths to avoid detection. So, although the program is not 100 percent successful, it has served to reduce supply over what it otherwise would be.

One important point to make in this context, that I promised Mexican officials to make whenever this issue came up, is their concern that our distress over the heroin problem in the United States will lead us to find scapegoats elsewhere. In this regard they believe that Mexico is likely to be No. 1 on the list of susceptibles for that distinction. They wanted me to emphasize that because we are unable to stop the distribution and use of heroin in the United States we have shifted the obligation to them.

In other words, it is not just Mexico that is failing to stop the drug traffic; it is the United States as well. Not that they are innocent, but they share with us the problem of being unable to stop the distribution.

I also have the feeling that we must do move if we are to be successful in this endeavor.

Mr. ROYBAL. Then the fault is twofold: They have not been completely successful?

Dr. DUPONT. That is right.

Mr. ROYBAL. And we have not been successful at all.

Dr. DUPONT. We haven't been completely successful.

Mr. ROYBAL. In doing anything about the narcotics problem in the United States, particularly as it crosses the border or comes in on ships, and in the many other ways it comes in?

Dr. DUPONT. Yes, sir.

Mr. ROYBAL. Also, is it not true that we have U.S.-based pharmaceutical companies that manufacture drugs in Mexico, that come through the border very, very easily?

Dr. DUPONT. Yes, that is so. There are also more drugs than heroin involved.

Mr. ROYBAL. Isn't it true that just 2 years ago American officials confiscated 5 tons of drugs made by American pharmaceutical companies in Mexico?

Dr. DUPONT. I am not sure about that particular number, but there was a very big problem a few years ago.

Mr. ROYBAL. Five tons, and I am being moderate. If I remember correctly, it is in excess of 5 tons. But nevertheless, our policing methods in the United States are such that we have not been able to do anything directly about this problem ourselves.

The blame I believe is twofold: The Mexican officials may be making an effort, but I don't think it is enough; far from being enough. On the other hand, I don't think that we are doing enough in this country.

The reason I brought in the American pharmaceutical companies'

activities in Mexico is that it is still continuing. We are permitting that to occur. Our own U.S.-based companies are responsible for much of the production of illicit drugs. Even though we passed a law here in Congress not so long ago making it illegal, it doesn't make any difference. I think our policing capabilities have to be increased.

Dr. DuPont. If I may, I would like to submit for the record a detailed response to that. Unfortunately, I don't have at my command right now the details concerning the involvement of the American companies in this problem. I will talk to Mr. Bartels this afternoon and provide you a formal response personally as well as for the record.

Mr. Roybal. I was going to ask you for that and wanted to know whether or not it is true that they continue with this operation.

[The information follows:]

SHIPMENT OF DRUGS MANUFACTURED IN MEXICO TO THE UNITED STATES

Mr. Bartels, Administrator of the Drug Enforcement Administration in the Department of Justice, states that there was a serious problem a few years ago caused by American pharmaceutical companies shipping psychotropic drugs to Mexico only to have them illegally brought back into this country. The Drug Enforcement Administration (DEA) has clamped down in this area, and Mr. Bartels tells me that there has been no evidence of this being a problem during the last 2 years. DEA has adequate legislative authority in this area and is fully satisfied with the results of their work. On the other hand, DEA is distressed that many foreign manufacturers of psychotropic substances continue to ship these drugs to Mexico, and that many of these drugs are then illegally shipped into the United States. DEA and the U.S. Government now have no way of stopping these shipments from foreign manufacturers. Mr. Bartels is convinced that when the Psychotropic Convention is ratified and in force, there will be an international control framework which will plug this gap in our drug abuse defenses. You may know that this treaty is now awaiting ratification before the Congress of the United States. We would welcome any assistance in helping achieve ratification.

NARCOTIC ADDICTION IN MEXICO

Mr. Roybal. Do you happen to know what the rate of narcotic addiction is in Mexico?

Mr. Du Pont. There is some disagreement on that figure. The Mexican officials allege they have virtually no narcotic addiction problem at all. I think that belief is a little supect but they hold to that view.

Mr. Roybal. Would you then concede there is some problem, but the rate of narcotic addiction is much lower than that of the United States?

Dr. Du Pont. I am not even sure of that, but as I mentioned, the Mexican officials tell me it is nonexistent.

Mr. Roybal. Let us then concede the point they do have some problem. Let's take the problem then of the Mexican American in the United States. Is there a problem in that area?

Dr. Du Pont. A very serious problem.

Mr. Roybal. But there is then a difference between Mexico, where they have no problem they want to admit, and here in the United States, where we do have a problem?

Dr. Du Pont. Yes, sir.

Mr. ROYBAL. Is that problem one that is fed by people who come to the United States illegally?

Dr. DUPONT. Yes; I think that contributes to the problem.

Mr. ROYBAL. Do you have any statistics that will show how much of these narcotics comes through the illegal alien?

Dr. DUPONT. No, but I believe that represents a major source.

Mr. ROYBAL. Do you know whether or not there are any statistics which show that more come through the California border than through the Texas or Arizona border?

Dr. DUPONT. Yes; there are. I will submit them for the record, but it is my understanding that the major supply route centers on the San Diego-Tijuana area. Although it is a problem all along the border, that area appears to be the most severely affected.

[The information follows:]

MAIN AREAS WHERE HEROIN CROSSES UNITED STATES-MEXICAN BORDER

It is difficult to identify the precise points along the border at which drugs enter the United States. Mr. Bartels, Administrator of the Drug Enforcement Administration, says that about 60 percent of the heroin coming into the United States now comes across the Mexican border and that most of this comes across at the ports of entry south of San Diego, Calif., and El Paso, Tex. Most comes by truck, car, or airplane. Only marihuana seems to be commonly carried by the illegal aliens entering the United States.

Mr. ROYBAL. I serve on another subcommittee, the Subcommittee on Treasury, Postal Service, and General Government, under which we have the Customs, and I happen to know a little bit and have learned a little bit from them as to what the problem really is. I think we are going to find we just can't wash our hands of these responsibilities.

Dr. DUPONT. That is true.

Mr. ROYBAL. I think the point has to be made over and over again so that my constituents, as well as people over the United States will look at this thing most realistically and come to the conclusion that a great deal more can be done, not only by your agency, but a great deal can be done, particularly on the part of law enforcement officials of the United States.

For example, I was surprised to find that in our own immigration service we had a ring of men who were charging those people who came across the border $250 for a green card. Some of those illegals were bringing in narcotics.

Dr. DUPONT. Yes.

Mr. ROYBAL. When we have that kind of a situation it seems to me we have a tremendous responsibility to do something about this particular problem.

Dr. DUPONT. Mr. Roybal, I observed at the U.S. border at San Ysidro the problem you are talking about. It is a very unfortunate situation when a Mexican national comes into the United States, is picked up and carried back across the border and then simply crosses again. They continue to attempt crossing two or three times and they may be successful. I think that is a fair statement of what is happening with some frequency.

Mr. ROYBAL. If you read some of the testimony we received on that same subcommittee, and some of the questions that I asked department officials, you will find that some of our own agents, our own

employees, aided individuals, who were suspected of being connected with narcotics rings in the United States, enter the country.

There is something else I would like to go into. I think this is a very important subject when I see what narcotics have been doing to youngsters in the area I represent. I represented Hollywood until last year. It has a high incidence of narcotic addiction. I represent an area in east Los Angeles which also has a high incidence and I see what is happening to these families.

Dr. DuPont. Twenty-five percent of all of the overdose deaths from heroin in the country are now occurring in Los Angeles County.

REDUCTION IN DRUG ABUSE COMMUNITY PROGRAMS

Mr. Roybal. I understand that. So the problem is there. This is why I don't understand why you are reducing your community programs by $19,457,000. How can you tell me your problem is great in my district in the State of California but you are reducing your program?

Mr. Isbister. The figure to which you refer is the reduction in the alcoholism community service program.

Mr. Roybal. How much are you reducing the narcotics program?

Mr. Isbister. There is an increase of $16 million in narcotics in order to maintain our commitment to support sufficient capacity to treat 95,000 addicts. But in order to do that we would not only require this increase but we will also have to ask the States and localities to increase their share.

Mr. Roybal. But you reduced training and research, didn't you?

Mr. Isbister. Training and research are both reduced in drug abuse but not the service delivery program.

Mr. Roybal. You reduce your programs altogether by $15 million.

Mr. Isbister. In the account for drug abuse there is proposed a $2.4 million reduction in research, a $10.8 million reduction in training, and $16 million increase in community programs. But the increase for community programs is not really a true programatic increase. There were a number of projects funded during fiscal year 1974 which did not have to be refinanced in 1975 but have to be picked up again in 1976.

Mr. Roybal. Right. But the direct grants to organizations in a particular community hasn't necessarily been increased?

Mr. Isbister. It hasn't been increased at all.

Dr. DuPont. It is being decreased. The Federal participation is going from 73 to 65 percent, which is forcing more responsibility on States and localities.

We have now a full 100-percent utilization in all federally funded drug abuse treatment programs and no capacity for new funding. Of those programs already funded there is diminishing Federal commitment.

Mr. Roybal. Then my original assumption is correct, that you are reducing the program?

Dr. DuPont. Yes, but the budget looks otherwise and——

Mr. Roybal. Why are you reducing it if the problem is as great as you have stated?

Dr. DuPont. The reason is the basic economic problem of controlling the overall Federal budget. Compared to many of our Federal companions, we think we have done fairly well.

Mr. Roybal. Do you realize the fallacy in that argument. Do you know the amount of money it is going to cost society if the condition increases by one-tenth of 1 percent? How much more it is going to cost in various other services. Just in robberies and thefts alone, it is going to cost much more than you are saving. So why is the program being cut?

Dr. DuPont. Because of the concern about the overall budget deficit, Mr. Roybal.

Mr. Roybal. Well, that is a very bad excuse.

Mr. Miller. Mr. Roybal, it is terribly difficult in formulating a budget with at least 300 categorical programs to go through program by program and say we should not decrease this one because of the economic situation but we should decrease that one. There are some exceptions. There are some initiatives that stand out so much we either let them stay level or move ahead. But every program in the Federal Government would have its advocates in the direction you are talking about. We can't argue with you in some respects on a cost-benefit basis, but it would be almost an impossibility to defend the budget to say we will move ahead in drug abuse but we will cut back on one of the education programs, or we will go ahead in this particular transportation program and phase out another program. It is terribly difficult.

Mr. Roybal. I am sure I am going to have programs in Los Angeles—and they are good ones out there incidentally—that are going to come to me complaining because you are either reducing it or cutting it out. Then when you see the problem that exists in Los Angeles, how am I going to explain to the people in that area why we cut back? Am I going to say because we have to reduce the budget, when in effect we are not reducing it?

Mr. Miller. The best answer we can give, I guess, and the best you can give, is that, if we can do something about jobs and inflation we will probably be better off in the end than if we increase our spending on categorical programs.

Mr. Roybal. I know of several cases, one woman had one of her sons killed in Vietnam, and the other who served in Vietnam is now a narcotics addict. She is not worried about any other problem except this one specifically.

Mr. Miller. You can imagine what our mail is.

MINORITY PARTICIPATION IN ADAMHA PROGRAMS

Mr. Roybal. I can't understand the reduction in this program and neither can anyone else in the United States.

The Director of the Institute of Mental Health expressed the view that minority participation at all levels should be increased. I suppose he took this position because of fancy programs we promulgated about making jobs available to all regardless of race, color, or creed. However, these programs never seem to function in practice.

I would like to get a breakdown of the number and amount in dollars that minorities have received in each of the following categories—I will give you a copy of this and be sure you answer this question adequately.

A. Grants awarded to minority group members.

B. Grants concerned with the study of minority groups particularly with regard to narcotic addiction.

I want to know the number of minority group consultants on your staff. Of the 1,591 employees I want to know how many are members of minority groups and particularly those having Spanish surnames.

The action that you have taken or planned to insure equitable participation by minority members in all levels of employment categories that you may have.

And finally have you developed any comprehensive plan setting forth the need of minority people and special problems that minorities face in each of these areas—alcohol, drugs, and mental health?

You are going to be back next year, and I am asking these questions because I want to make a little comparison. As you know, since you have appeared before our committee before, I like to ask these questions and then next year make a little comparison and find out just how well you are doing. And if I am elected next year I hope to be back on this committee and I hope to be able to review this problem with you and find out just exactly what has happened.

I am also going to remind you, if you cut any programs, particularly in an area that needs them so badly, that I warned you of the consequences. We will see if then we can't come to some realization that if we are going to fight something we have to fight it with every weapon we have. We are not going to win a battle if we just take the attitude that we have got to save our pennies here and there when we spend them foolishly somewhere else. There are areas where we are spending our money foolishly.

[The information follows:]

MINORITY PARTICIPATION IN ADAMHA PROGRAMS

Grants to Minority Institutions

Information on the number and dollars of grants awarded to minority group members is unavailable at this time. Racial minority data is not currently requested on grant applications and consequently does not exist in our grant information systems. However, we have been advised of the legal requirement to request that grant applicants specify pertinent data regarding the extent to which minority groups will be represented in projects seeking HEW funds. A supplement to grant application forms will be developed requesting information concerning minorities, sex, etc. and such information will be collected in the future.

Research Studies of Minority Groups

	Number	Amount
NIMH	26	$3,144,000
NIDA	11	818,000
NIAAA	4	166,000
TOTAL	41	4,128,000

Minority Consultants to ADAMHA

	Black	Spanish-American	American-Indian	Asian	Total
OA	5	2	0	1	8
NIMH	3	1	0	3	7
NIDA	5	0	0	0	5
NIAAA	4	1	2	1	8
Total	17	4	2	5	28

Minority Members of ADAMHA Review Committees

	Black	Spanish-American	American-Indian	Asian	Total
NIMH	25	10	5	3	43
NIDA	1	0	0	0	1
NIAAA	2	2	1	1	6
Total	28	12	6	4	50

Action Taken to Ensure Equitable Participation by Minority Group Members

Among the most significant efforts to ensure equitable participation by minority group members are: minority group coalitions for research and development centers to provide technical assistance to minority group organizations, and a fellowship program for minority group students funded by NIMH and administered through five professional associations with minority group staff and an advisory committee. These efforts will surface

the major mental health issues facing the minority communities, formulate appropriate research efforts, and increase the number of minority mental health professionals. In addition, the National Advisory Mental Health Council and top level staff are actively engaged in improving efforts in addressing the issue of equity.

Action Taken or Planned to Ensure that All Research Training Grants Involving Minorities are Free from Racial Prejudice

Minority groups are represented in the review process at the peer level through the Initial Review Group involving persons from the behavioral and social sciences and at the National Advisory Mental Health Council for final review. Staff is sensitive to this important area and in conjunction with the groups involved in the review process can effectively ensure that research training grants involving minorities are free from racial prejudice. An evaluation study of our efforts in this area is being completed and we will be reviewing the findings with the objective of improving our efforts.

Comprehensive Plan Setting Forth Needs of Minority People

There is no formal comprehensive plan setting forth the needs of minority people and special problems of minorities in mental health. A Center for Minority Group Mental Health Programs has been established within the NIMH since November, 1970, which serves as a focal point for Institute activities which bear directly on improving the mental health of minority groups and on increasing the number and competence of minority members engaged in mental health research, training, and services.

The Center has also sponsored several conferences including professionals and leaders in mental health concerned with the mental health problems of minorities.

Five Research and Development Centers have been established to design, conduct and implement research programs relevant to minority groups. This project has been selected for tracking and monitoring as part of a DHEW OPS objective. One additional center is still to be established related to Puerto Rican research.

At the September, 1974 meeting of the NAMHC, a resolution was passed recommending that a subcommittee be set up to study the problem of more support for minority related research and training. The resolution establishing the subcommittee read:

> "The National Advisory Mental Health Council shall convene a committee to confer with the staff of the NIMH and other appropriate consultants, to examine the level of funding of the Center for the studies of Minority Group Mental Health, and to develop a formula for the expenditure of available NIMH funds which would increase the level of minority projects from within the Center for minority Group Mental Health Program and/or the Institue as a whole. In addition, it will be the charge of this committee to review the impact of this funding modification on other NIMH programs and priorities. After consideration

of these issues, the committee will make a report to the NAMHC for its approval at the December 3 meeting."

The subcommittee report and recommendations to the NAMHC to improve the quantity and quality of minority activities was distributed at the April meeting to the Institute and the Minority Center's Advisory Group for comment and review.

The NIAAA's approach to minority problems in relation to alcoholism has been to recognize that many minority groups in our society have experienced exceptional deprivation. In an effort to be responsible to the needs of such populations, the Institute has placed heavy emphasis on providing funding support to these target populations.

The Institute's philosophy and operational policy in the treatment area have been to foster the assumption by the special population groups of the responsibility for planning and initiating appropriate programs. We feel that the direct funding of projects serving the special population will give these groups a substantial negotiating position to gain entrance into the mainstream of health and social service care from which they have been traditionally excluded, particularly for the treatment of alcoholism.

ADAMHA MINORITY ADVISORY COMMITTEE

An ADAMHA Minority Advisory Committee was established February 10, 1975, by the Secretary, pursuant to Public Law 92-463, the Federal Advisory Committee Act of October 6, 1972. The Committee consists of ten members, including the Chairman. Members are appointed by the Administrator, ADAMHA, from leading authorities in the fields of alcoholism, drug abuse, and mental health, and representatives of the general public who have wide knowledge of minority alcoholism, drug abuse, and mental health issues and are ethnically and geographically representative of the Nation. Members are invited to serve for overlapping two-year terms.

The Committee provides advice to the Administrator, ADAMHA, on policy, programs and activities regarding minority alcohol, drug abuse, and mental health matters, and makes recommendations for possible solutions which meet the needs and concerns of minority groups throughout the United States. The Committee functions in an advisory capacity to the Administrator, ADAMHA, on these matters which relate to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Drug Abuse (NIDA), and National Institute of Mental Health (NIMH). Meetings are held at least every two months and, as with all public advisory committees, are open to the public. Authority for the Minority Advisory committee expires February 10, 1977, unless the Secretary formally determines that continuance is in the public interest.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Stokes.

Mr. STOKES. Thank you, Mr. Chairman.

Is there someone here who can give me some information regarding a study you are doing entitled "Project Identification" which has to do with tracing of firearms used in violent crimes? You are not aware of it?

Dr. DUPONT. It sounds like a Justice Department program to me.

Mr. STOKES. We were informed it was being done by your department. If you are not aware of it, I will withdraw the question.

Dr. BROWN. If you give us the information you have, we will be glad to try to trace it.

Mr. STOKES. My information is that it is a study being done in several cities around the United States by your bureau, and it has to do with tracing guns that are used in violent crime.

Dr. BROWN. There is only a possibility, Mr. Stokes, that it is a research project in our crime and delinquency section. There is not enough information to ring a bell. We will try to track it down.

Mr. STOKES. I would appreciate it if you would.

For the record, in the event it is lodged within this department, Mr. Chairman, I will have some further questions to ask regarding it if I may have unanimous consent to do that.

Mr. FLOOD. Without objection that will be done, of course.

STUDY ON USE OF FIREARMS IN VIOLENT CRIMES

The Agency's records have been reviewed and no study on the use of firearms in violent crimes is being conducted by the Alcohol, Drug Abuse, and Mental Health Administration.

HEROIN USE BY RACE

Mr. STOKES. In your comment with reference to the fact that heroin usage is now on the increase, can you tell us whether there is a greater percentage of increase of heroin usage in the black community or in the white community, or has the increase occurred in both?

Dr. DUPONT. It is in both. I think the biggest increase which occurred initially in the late sixties was in the minority community of the cities, such as Cleveland, which is predominantly black. In places like Los Angeles, the first wave of addiction occurred predominantly among Mexican Americans.

Later, in 1971 and 1972, there was an increase among suburban and nonminority populations.

Today the evidence is somewhat mixed. Our hepatitis indicators suggest the biggest growth at present is in the nonminority population, but other indicators suggest there is also new growth of the heroin problem in the minority population.

As you see, the most current data is somewhat unclear on this point. But as an overall trend, it seems that minority groups are affected first and nonminority groups later.

Mr. STOKES. On the recent increase, do you have any further data as to where it exists?

Dr. DUPONT. Mr. Isbister mentioned one of the areas. It has now spread to smaller communities, and it is a source of considerable concern to us that our resources, which are fully committed, are almost totally devoted to large communities. Therefore our capacity to respond to problems of small communities is very, very limited.

INCREASES IN DRUG USAGE

Mr. STOKES. You mentioned the area of heroin where we are experiencing an increase. Isn't it true with respect to the total drug situation that in all areas of usage of drugs there is an increase, and that there is no area in which there has been any decrease?

Dr. DUPONT. I think that is generally the case. The possible exception would be with amphetamines where there have been rather strict quotas established. I think some reduction in its abuse has been evidenced.

Mr. STOKES. Then, in talking about marihuana, hashish, cocaine, or any of the other use of drugs, we are talking about a situation where there has been no decrease; aren't we?

Dr. DUPONT. Except for the period 1972 and 1973 with respect to heroin; yes, sir, you are correct.

Mr. STOKES. So in reality then we are cutting back at a time when we are admitting that we have a significant increase in all of these areas?

Dr. DUPONT. Yes, sir.

USE OF METHADONE

Mr. STOKES. Let me ask you about whether or not you have done any studies with reference to methadone versus detox centers and what those studies have revealed in terms of any progress in treatment and rehabilitation of drug addicts?

Dr. DUPONT. Of course, the word "detox" can have various meanings. To some people it means the use of methadone in decreasing doses. The FDA requires that only the first twenty days of methadone treatment be defined as "detox." For other people detox means a nonmedical or nonpharmacologic treatment where the person is going cold turkey, usually in a treatment residence of some kind. Both of those go on.

The majority of people who are coming into drug treatment programs are not interested in a prolonged methadone treatment, but simply in detoxification. On the other hand, there are a significant minority of people coming in who are interested in longer term treatment with methadone. Our approach has been to provide alternatives to these individuals. Basically, we found both are quite effective. For example, the methadone maintenance as well as the detox showed a cost-benefit ratio of about 40 to 1 in a recent study.

Mr. STOKES. You mentioned the methadone treatment situation, and I am concerned about the involvement of the Federal Government in terms of supplying of methadone to heroin addicts because what we are actually doing, aren't we, in the utilization of methadone treatment, is really creating a new set of addicts as a result of the usage of methadone?

Dr. DUPONT. I don't know that I would call it a new set of addicts. As you mentioned, methadone is only used in the context of preexisting heroin addiction of at least 2-years duration.

The fairest statement would be that those individuals who choose methadone maintenance are trading a relatively malign addiction for a relatively benign addiction.

Maybe I could sketch very briefly the outlines of the Federal Government's involvement with methadone to help focus some of the questions.

There are about 75,000 people in treatment with methadone in the country today. This is about 60 percent of the total opiate-dependent people who are in treatment in the United States. In the Federal Government about a third of the people who are in treatment altogether, or about 40 percent of the heroin dependent individuals, are in treatment with methadone. In other words, the Federal Government does not fund as much methadone treatment as do non-Federal sources.

In numerical terms, only about 26,000 of the 95,000 treatment slots funded by the National Institute on Drug Abuse are methadone slots.

All methadone, however, whether funded by the Federal Government or not, is controlled by the Federal Government through the FDA and Drug Enforcement Administration. So everyone who uses methadone uses it in a closed distribution system carefully monitored by the Federal Government. In that sense the Federal Government is participating in all methadone programs.

METHADONE OVERDOSES

Mr. STOKES. I am interested when you say substitution of methadone is a relatively benign form of addiction for a malignant addiction.

Dr. DUPONT. Yes.

Mr. STOKES. Is that really true in light of the fact that death by methadone overdosage is now a major problem?

Dr. DUPONT. The people who are dying from methadone overdoses, Mr. Stokes, are not people in methadone treatment programs. The people who are dying from overdoses of methadone are people who have obtained methadone from illicit sources and who are not in methadone programs. There is a serious problem.

You might be interested in knowing that about 85 percent of all the methadone overdose deaths occurring in the country are in New York City. That is the only place where there has been a significant number of such deaths occurring recently. My point is that a patient being sustained on methadone in a treatment setting is subject to a benign addiction. Methadone can be malignant under any circumstances for the nonprogram participant. In that sense your point is valid since in those circumstances it is not benign. Because this kind of problem can develop, the treatment of patients with methadone is often not an attractive treatment alternative from the community point of view. It certainly requires a great deal of control.

ILLEGAL DISTRIBUTION OF METHADONE

Mr. STOKES. Wasn't there a recent GAO report which revealed the fact that there is illicit methadone on the street, much of which has come from the legitimate federally monitored methadone program?

Dr. DUPONT. Yes, that is correct.

Mr. STOKES. And that which is on the street is creating a major problem by, first, the creation of a whole new set of addicts who are getting it on the streets, and second, the deaths which are occurring as a result of it being on the street?

Dr. DuPont. Yes, Mr. Stokes. As shown by the GAO study and other studies as well, methadone has found its way onto the illicit street market throughout much of the United States. The potential problems which can result from programs which are inadequately run are an important consideration in the decision to establish methadone treatment centers.

I think it is important to recognize we have not seen a significant methadone addiction problem; that is, individuals who are not addicted to heroin but who could develop methadone addiction following their introduction to it through illicit channels. While that has been a grave concern, we have not seen that problem to any significant degree.

The problem with illicit methadone is the one you mentioned first, the overdose death problem. That happens precisely because the individual doesn't take it on a daily basis; using it only intermittently he does not build up a tolerance and therefore runs the risk of overdose death. That is a problem but it is not the primary problem of methadone.

Mr. Stokes. If we can resume the hearing at this time, my next question also relates to the question of methadone which we were pursuing at the time I had to leave for the floor.

Do we have any idea as to how much methadone is now on the streets, whether it be New York or Cleveland or any other locality?

Dr. DuPont. Yes; we have a number of very good measures, one of them being the overdose deaths around the country. I would be happy to submit for the record studies which show the rate of overdose deaths is not generally increasing. In relationship to the overall heroin population, the problem has shown a significant increase only in New York City.

In some cities we have a much more detailed kind of assessment of this. In the District of Columbia a number of parameters are measured, including the rate of methadone use of people coming into Superior Court. This measure is based on a checking of all urines of such individuals over the past 3 years.

During that period, there has been a decline in the rate of illicit methadone use of those appearing in court from about 12 percent at the peak in February of 1972, to the current level of under 1 percent. By comparison, the percent of use of heroin in the District of Columbia has run at a peak of about 35 percent to a low of 8 percent; it is currently somewhere between 12 and 15 percent.

Mr. Stokes. You will further elaborate for the record?

Dr. DuPont. Yes, sir.

[The information follows:]

METHADONE DIVERSION

While direct data on the amount of methadone being diverted from treatment programs to unintended uses is not available, recent information from selected medical examiners and hospital emergency room reports suggests that the proportion of drug related episodes in which methadone was mentioned remained relatively constant during 1974. In addition, only the New York area shows proportionally more reports of methadone than of heroin.

The following table shows the number and percentage of heroin and methadone reports among all drugs reported by selected emergency rooms and medical examiners in four metropolitan areas of the country. Monthly totals are shown for March, June, September and December 1974.

EMERGENCY ROOM DRUG REPORTS 1974

City	Drug	March	%	June	%	Sept	%	Dec	%	Total Drug Reports 1/ Mar	June	Sept	Dec
New York	Heroin	64	9	78	12	75	13	78	13				
	Methadone	131	19	123	19	113	19	80	13	674	635	583	607
Wash.	Heroin	10	1	13	2	14	3	11	2				
	Methadone	4	.5	5	.9	6	1	3	.5	683	534	554	565
Detroit	Heroin	85	8	132	11	161	13	153	14				
	Methadone	19	2	28	2	40	3	31	3	1107	1123	1280	1115
Los Angeles	Heroin	115	10	160	11	212	14	165	13				
	Methadone	10	.8	11	.8	11	.7	8	.6	1167	1403	1505	1244

MEDICAL EXAMINER DRUG REPORTS 1974

City	Drug	March	%	June	%	Sept	%	Dec	%	Total Drug Reports 1/ Mar	June	Sept	Dec
New York	Heroin	27	7	18	7	33	13	32	13				
	Methadone	117	30	73	27	68	26	57	23	385	266	262	245
Wash.	Heroin	1	4	0	--	3	30	5	36				
	Methadone	1	4	0	--	0	--	1	7	21	12	10	14
Detroit	Heroin	7	19	4	11	3	9	12	26				
	Methadone	1	3	0	--	0	--	1	2	36	35	33	46
Los Angeles	Heroin	49	25	44	28	39	22	40	28				
	Methadone	0	--	0	--	3	.2	1	.1	194	160	181	145

1/ Each drug mentioned in the cases reported by participating emergency rooms and medical examiners is counted separately. Thus, an individual case involving two drugs would be counted twice.

Source: Drug Enforcement Agency (DEA)

Passage of the Narcotic Addict Treatment Act of 1974 gave the DEA authority to register practioners who dispense narcotic drugs for maintenance or detoxification treatment services. Such registration seeks to strengthen standards of treatment programs in the areas of record keeping, security of drug stocks, and general treatment services. While this act should be effective in reducing the national problem of methadone diversion by patients and clinic personnel, the final DEA regulations which became effective in December, 1974, have not yet had time to impact upon statistics comparing cases of heroin and methadone overdoses.

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Controlling the Abuse of Illicit Methadone in Washington, DC

Mark H. Greene, MD; Barry S. Brown, PhD; Robert L. DuPont, MD

Methadone hydrochloride has been found to be medically safe when administered in the setting of a well-organized heroin addiction treatment program. The abuse of illicit methadone, outside the therapeutic setting, has aroused considerable controversy, particularly with regard to the public health hazards of primary methadone addiction, overdose, abuse, and childhood poisoning.

We attempted to document the nature and extent of these negative aspects of the diversion of methadone into the illicit drug market, using data collected between 1969 and 1974 in the District of Columbia. The data illustrate the severe problems created by the widespread availability of illicit methadone, and document that, with the appropriate controls, the large-scale use of methadone in addiction treatment is feasible with minimum risk of methadone addiction and overdose in the community.

Methadone, a synthetic narcotic, was originally introduced as an alternative to opiate analgesics with high addiction potential. It subsequently was found to possess a number of properties that led Dole et al to test its utility in treating heroin-dependent individuals.[1] Today, methadone hydrochloride is widely used in the treatment of heroin addiction. In the setting of a well-organized treatment program, methadone appears to be "medically safe, with minimal side effects and no toxicity" for the addict treated with it.[2]

As drug abuse has emerged as an issue with significant political and racial overtones, debate has grown regarding the dangers of using methadone. Early research documenting the abuse potential of methadone has been cited in this regard,[2,3] as well as the occurrence of methadone overdose,[2-4] childhood poisoning,[5] methadone abuse,[10,11] and diversion of methadone by patients in treatment into the illicit drug market.[10-12] It has been stridently claimed, although poorly documented, that methadone is an unmitigated menace to the community. Many people now believe that the use of methadone in addiction treatment is followed, of necessity, by a flood of illicit methadone in the streets of their city, with concomitantly high rates of methadone-overdose deaths and primary methadone addiction (addiction to methadone prior to addiction to heroin or other opiates). In spite of this controversy and the social importance of this issue, there has been no systematic attempt to verify the nature and extent of these negative aspects of the use of methadone in addiction treatment.

This report summarizes Washington, DC's experience following the introduction of methadone as an addiction-treatment tool, documenting the problems encountered as a result of methadone diversion (diversion of methadone intended for therapeutic use in heroin addiction treatment programs into the illicit drug market), and the results of control measures designed to reduce these problems. The data suggest that, given appropriate controls, it is feasible to use methadone on a large scale in addiction treatment while simultaneously minimizing the risk of methadone addiction and overdose in the community.

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From the Bureau of Epidemiology, Center for Disease Control, US Public Health Service, Atlanta (Dr. Greene); the Bureau of Research and Development, Narcotics Treatment Administration, Department of Human Resources, Government of the District of Columbia, Washington, DC (Dr. Brown); and the Special Action Office for Drug Abuse Prevention, Executive Office of the President, Washington, DC (Dr. DuPont).

Reprint requests to the Special Action Office for Drug Abuse Prevention, 726 Jackson Place NW, Washington, DC 20506 (Dr. DuPont).

METHODS

The data were collected through the activities of the Narcotics Treatment Administration (NTA), the District of Columbia's large, multimodality addiction treatment program established in late 1969.[14] By the end of 1973, NTA had treated in excess of 15,000 heroin users. Approximately 80% of these patients received methadone, 60% in a detoxification program and 20% in a maintenance program.

The NTA Drug Abuse Surveillance System provided data on methadone-related deaths, methadone seizures made by the DC Metropolitan Police, and urine screening for methadone at two different sites. Details of this data-collection system have been previously reported.[15,16]

Briefly, data on methadone-related deaths were collected beginning in 1969 with an improvement in the system occurring in July 1971 with the establishment of a medical examiner system in the District of Columbia. Data have been collected in a uniform fashion since that time with no change in the system for classifying drug-related deaths.[4] Cases reported as acute methadone-overdose deaths all had positive toxic reactions to methadone and no other apparent cause of death. Deaths due to homicide, suicide, accident, and natural causes were excluded. Cases included in this report include those in which methadone was the only drug detected, as well as cases in which both methadone and morphine were detected, since our data indicate that methadone plays the critical role in these latter cases.[4]

The DC Metropolitan Police Narcotics Squad tabulated all seizures of illicit drugs on a monthly basis. Methadone seizures are reported here as a percent of all illicit drugs seized. Police enforcement policy and data collection procedures were unchanged during the course of the study period.

Urine testing for methadone was performed at two locations. First, heroin addicts enrolling with NTA were tested at NTA's Central Medical Intake Unit. An average of 250 patients were tested each month. Second, urine specimens were obtained from arrestees newly incarcerated in the DC Superior Court Central Lockup, a holding facility in which arrestees await arraignment. An average of 85% of the 1,000 individuals incarcerated each month underwent this urine drug-screening procedure. These two testing programs represent different samples of the total population of individuals using methadone. There is some overlap between the two samples since one third of NTA program admissions are referrals from the criminal justice system. However, the NTA admission data include predominantly voluntary referrals, and the Superior Court data include individuals who are not referred to the treatment program.

The NTA's Bureau of Research performed a series of five surveys ("methadone diversion surveys") between January 1972 and December 1973 on addicts entering treatment. Sample sizes ranged from 100 to 150 consecutive individuals encountered at

NTA's Central Medical Intake Unit. With minor variations, the same questionnaire instrument was used in all surveys. Detailed data on each respondent's experience with illicit methadone were sought.

Statistical tests of significance employed in evaluating the data included χ^2, Student t test, the Pearson Product Correlation Coefficient (r), and the Mann-Whitney U Test. Trends were demonstrated by means of a linear regression line fit by the method of least square. Significance of trends was tested by applying the Student t test to the slope (b) of the linear regression line.

HISTORICAL BACKGROUND

The following is a brief summary documenting the growth of the methadone-abuse problem in Washington, DC, and those measures instituted to control this problem.

The Growth of Methadone Abuse

Fall 1969.–Methadone introduced in the District of Columbia on a small scale by private physicians and public programs

January 1970.–District of Columbia's first methadone-overdose fatality

February 1970.–The NTA established–large-scale government program; high-dose methadone maintenance used (mean, 100 mg/day; maximum, 160 mg/day; supervision of take-home medication inadequate

Fall 1970.–Beginning of large-scale methadone sales by DC private physicians

Winter 1970.–Start of education campaign regarding the nature of methadone

March 1971.–Accidental methadone-poisoning death of a 2-year-old child

Winter 1971.–Heroin shortage in the streets of Washington

January to February 1972.–Fourteen fatalities related to methadone overdose

March 1972.–First NTA methadone diversion study–methadone readily available in the streets of Washington; NTA an important source of methadone reaching the streets

Control Measures

March 1971.–Intensified education campaign regarding dangers of unsupervised methadone use; introduction of child-proof, unit-dose methadone medication bottles; introduction of lockboxes for NTA patients to store home medication

March 1972.–Suspension of methadone prescribing by DC private physicians and pharmacists

May 1972.–Introduction of noninjectable liquid methadone preparation by NTA

September 1972.–Improved NTA clinic security (narcotics safes and alarms)

October 1972.–Conviction of local physician for prescribing methadone for profit (lost license, $150,000 fine, and 15 to 45 years in prison)

February 1973.–Introduction of more stringent take-home criteria; decrease in maximum number of doses of take-home medication from four to two; decrease in maximum dispensed dose of methadone from 160 mg to 80 mg[4]

March 1973.–Last of the methadone-for-profit physicians closed down; introduction of computerized methadone accounting by NTA

July 1973.–Decrease in maximum take-home dose of methadone from 80 mg to 60 mg

RESULTS

These control measures were introduced gradually between mid 1971 and mid 1973. Changes in methadone use associated with this effort can be documented as follows:

Methadone-Overdose Deaths

There were no known opiate-overdose deaths related to methadone prior to 1970. As depicted in Fig 1, there were 17 such deaths (2.2 per 100,000 general population in the District of Columbia) in 1970. The death rate rose to a peak of 51 deaths (6.7 per 100,000) in 1972, and decreased to 14 deaths in 1973 (1.8 per 100,000). The declining death rate was first observed in the fourth quarter of 1972. Furthermore, of the 14 deaths in 1973, only three occurred during the last six months of the year. There were two methadone-related deaths in the first six months of 1974. This represents an annualized methadone-overdose death rate of 0.5 per 100,000, over 90% decrease from the peak death rate of 7.7 cases per 100,000 observed during the first six months of 1972.

Police Methadone Seizures

There has been a steady decline in the number of methadone seizures made by the DC Metropolitan Police since early 1972 (Fig 2). Although the number of methadone seizures has been small, there were one third as many such seizures in the first quarter of 1974 compared to the first quarter of 1973. This is a statistically significant downward trend ($r=-.71$, $t=-2.88$, $P<.05$). It is of interest to note that there has never been a seizure of a large quantity of methadone in the District of Columbia. Typically, only one or two doses of the medication have been found at any one time. This suggests that methadone is not part of the underworld drug distribution network; rather, the distribution chain is very short, most frequently directly from a patient to a friend. Such a distribution pattern, unlike that of heroin with its multilevel system, is not readily susceptible to police intervention.

Methadone-Urine Screening

Of the two sites at which testing is performed, the data obtained from the arrestee population at the DC Superior Court seem to be the more reliable index of illicit methadone use prevalence. This is because these data are obtained from individuals who did not know their urine might be tested at the time they made their decision to take a particular drug. The fact that they happened to be arrested provided the opportunity of obtaining a urine sample for drug screening. In the data reported here, arrestees who were receiving methadone from an official treatment program were eliminated from the sample. As indicated in Fig 3, the percentage of urine specimens found to contain illicit methadone has decreased from a peak of 8.4% during the first quarter of 1972 to 2.7% in the second quarter of 1974. This decline is statistically significant ($r=-.88$, $t=-5.46$, $P<.001$).

The urinalysis data for illicit methadone, as detected at NTA's Central Medical Intake Unit, are more difficult to interpret, being biased by unknown factors relating to users' decisions to enter treatment. It would appear, however, that there is an inverse correlation between the number of urine specimens in which heroin (morphine/quinine) was detected and the number of specimens in which illicit methadone was detected (see Fig 4). Most patients use opiates right up to the time of their admission into treatment. Which opiate they choose is a function of

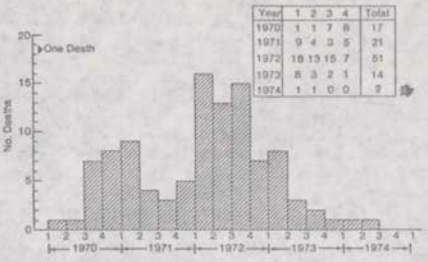


Fig 1.—Acute opiate-overdose deaths in which methadone hydrochloride played causal role in District of Columbia, by quarter (1970 through second quarter of 1974).

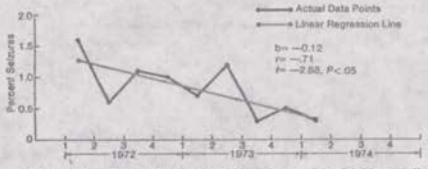


Fig 2.—Illicit methadone hydrochloride seizures by DC Metropolitan Police, by quarter, expressed as percent of all seizures of illicit drugs (1972 through first quarter of 1974). Regression line fit by least square method.

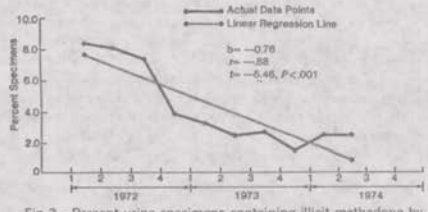


Fig 3.—Percent urine specimens containing illicit methadone hydrochloride at DC Superior Court, by quarter (1972 through 1974). Regression line fit by least square method.

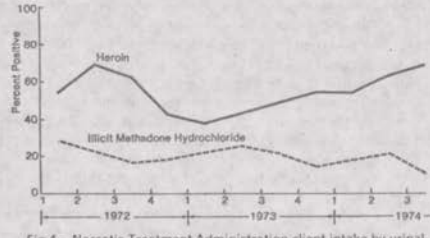


Fig 4.—Narcotic Treatment Administration client intake by urinalysis for heroin and illicit methadone, by quarter (1972 through 1974). Results expressed as percent of all urine specimens with positive finding for each drug.

the price and availability of heroin and methadone. As methadone availability has declined, the likelihood of patients having heroin detected in their urine has increased. These methadone data were similar to the Superior Court data in that there was a downward trend over the 2½-year period of observation. This decline was not statistically significant.

NTA Methadone Diversion Studies

Five surveys were performed between January 1972 and December 1973. Selected results from the NTA methadone diversion studies are presented in Tables 1 and 2. The data disclosed that a significant proportion of patients entering treatment had used illicit methadone *at some time* in their drug-abuse careers. Forty-six percent of those interviewed in the first quarter of 1972 admitted to the use of illicit methadone. The highest rate was 57%, observed in the fourth quarter of 1972. Comparison of this most recent figure to the results from one year earlier shows a statistically significant decrease ($\chi^2 = 14.5$, $P < .001$). With respect to *current use* of illicit methadone (ie, use within the month prior to interview), 20% of the most recent sample were so classified. This is a significant decrease from the rate of current use (39%) reported in the last quarter of 1972 ($\chi^2 = 11.3$, $P < .001$).

Almost all respondents (92%) reported that they took their methadone orally, and the most frequent reason for using methadone was the user's desire to treat his heroin addiction (79%). An average of 10% of the respondents to the five surveys reported that they used illicit methadone to induce euphoria. In general, users reported having obtained their illicit methadone from the same person who normally sold them heroin.

Most users reported that they had begun their opiate-abuse careers with heroin. In the survey done in the first quarter of 1972, a total of 21% of the respondents indicated that methadone had been the first opiate they had

Table 1.—Variables Remaining Stable During Observation Period*

Variable	Mean, %
Route of methadone hydrochloride administration	
Oral	92
Intravenous	3
Both	3
No answer	2
Frequency of methadone use during the month prior to interview	
Daily	16
Weekly	27
Monthly	25
None	32
Reason for using methadone†	
Treatment	79
Euphoria	10
Curiosity	3
Other	28
Overdose experience reported‡	
None	79
Heroin	20
Methadone	1

* Data reported represent mean of all five surveys.
† Total exceeds 100% as result of multiple responses from some individuals.
‡ These data were obtained on last two surveys only.

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Table 2.—Variables That Have Changed During the Observation Period*

Variable	Survey Performed During 1st Qtr 1972	2nd Qtr 1972	3rd Qtr 1972	4th Qtr 1972	4th Qtr 1973
Ever used illegal methadone hydrochloride	46	41	55	57	34
Currently using illegal methadone†	28	29	34	39	20
Type of methadone used					
Tablet	88	33	26	10	2
Liquid	2	44	48	79	74
Both	10	23	26	11	14
Methadone purchased from					
Friend	53	57	56	57	33
Dealer	36	31	37	28	52
Both	9	9	4	9	2
No answer	2	3	3	6	13
Reported origin of methadone					
NTA‡	29	42	61	52	57
Private physician	32	15	7	6	4
Other	0	7	2	4	4
No answer	39	36	30	38	35
Methadone availability during 3 months prior to interview					
Increased	NA	NA	NA	22	15
Decreased	NA	NA	NA	35	45
Unchanged	NA	NA	NA	43	40
First opiate ever used					
Heroin	79	85	87	88	100
Methadone	21	15	13	12	0
Highest risk of overdose					
Heroin	53	41	32	31	14
Methadone	31	31	29	41	54
No difference	16	28	39	28	32
Median cost of one dose of illicit liquid methadone	NA	$7	$8	$10	$11

* All data reported in percent unless otherwise noted. Data not obtained in this survey indicated by NA.
† Used illegal methadone during month prior to interview.
‡ Narcotic Treatment Administration indicated by NTA.

used. This proportion has steadily declined as measures to control methadone diversion were implemented. Of those interviewed in the most recent survey (fourth quarter 1973), *none* reported methadone as the first opiate used. Less than 1% of all users interviewed reported having been addicted to methadone *prior to* having been addicted to heroin.

In general, methadone was used on a sporadic basis with only 16% of the respondents describing daily use of methadone during the month prior to interview. It was rare for anyone to use illicit methadone regularly for a prolonged period. During the two years of observation, the proportion of users interviewed who reported having used *no* illicit methadone during the month prior to interview rose steadily from 24% to 39%.

The last two surveys inquired about the overdose experience of the respondents. The largest proportion of respondents (79%) reported that they had never experienced an overdose with either heroin or methadone. Heroin overdoses were much more frequently reported than were methadone overdoses (20% vs 1%).

Those interviewed were asked to report their impression regarding the origin of the methadone they purchased in the streets. The response to this question changed substantially during the two years of observation, as methadone dispensing by private physicians declined. Thus, 32% of those interviewed in the first quarter of 1972 reported that their illicit methadone was originally obtained from a private physician. This proportion has gradually declined to 4% of the most recently studied sample. During the same period, the percent of the people claiming NTA as the original source of the medication rose from 29% to 57%. In support of the belief that NTA was a major source of illicit methadone was the report by 41% of those interviewed that there was an NTA identification label on the bottle containing their illicit methadone.

The last two surveys inquired about users' assessment of the availability of illicit methadone in the District of Columbia three months prior to the interview. The *least* frequent response was that methadone availability had increased (22%, 15%) with the remaining responses about equally divided between availability decreased (35%, 45%) and availability unchanged (43%, 40%). Information on the cost of a dose of liquid methadone in the street market has been collected as of the second quarter of 1972. At that time, a bottle of illicit methadone cost $7 (median). As of the most recent survey in the last quarter of 1973, a bottle cost $11. This is a statistically significant increase ($t = 3.77$, $P < .01$).

Finally, this series of surveys provided data verifying the attitudes of opiate users with regard to the relative dangers of heroin and methadone. Data in Table 2 are illustrative of the attitudinal change that has occurred in the District of Columbia during the past two years. When asked whether heroin or methadone was more likely to cause a nonfatal overdose, respondents in the first survey believed that *heroin* was more dangerous in this regard (53%) than methadone (31%). A small proportion (16%) believed that the two drugs were equally dangerous. The most recent survey discloses that 54% now consider *methadone* more likely to produce an overdose with 32% believing the two drugs are equally dangerous, and only 14% that heroin is more dangerous. This trend is also seen in attitudes regarding the addiction potential and the likelihood of fatal overdose associated with the two drugs.

COMMENT

In the early stages of the use of methadone in the treatment of heroin addiction, attention was focused on designing an effective addiction-treatment strategy and providing the desired services to as many heroin users as quickly as possible. The warnings by early investigators regarding the abuse potential of methadone were overlooked in the rush to respond to what had been designated as a national crisis.[3-5] As a result, controls on the use and distribution of methadone were not built into many treatment programs. When methadone was subsequently diverted into the illicit drug market, a serious problem of methadone abuse emerged. Deaths from methadone overdose were the most visible and tragic manifestation of this problem. Many drug workers, community leaders, and politicians responded to this issue with a blanket condemnation of methadone. It was assumed that methadone-overdose deaths, childhood poisoning, primary methadone addiction, and widespread use for purposes of inducing eu-

phoria were the inevitable consequences of using methadone in the treatment of heroin addiction. The Washington, DC, experience with methadone diversion and abuse can help separate fact from fantasy in this highly complex issue.

First, it is clear that, in the absence of strict controls, methadone can and did become a serious drug abuse problem. High availability and abuse of illicit methadone in the early years of Washington's heroin treatment efforts have been verified with data on methadone-overdose deaths, urine screening, police seizures, and survey information elicited from heroin users. The most serious manifestation of this problem was the large number of methadone-overdose deaths.

The data also show that the issue of illicit methadone abuse is more complicated than it might appear on the surface. Thus, primary methadone addiction (ie, the addiction to methadone prior to ever being addicted to heroin) has not emerged as a significant problem in the District of Columbia. Less than 1% of the users surveyed were in this category in spite of the verified scarcity of heroin in the city.[15-18] Methadone was the first opiate ever used in a minority of individuals (21%), even when illicit methadone availability was at its maximum. This figure has since declined to zero as controls were introduced. Although methadone-overdose deaths occurred in serious numbers (even a single death from methadone is too many), the number of nonfatal heroin-overdose episodes reported in user surveys was 20 times the number of methadone-overdose episodes. There has been only one case of fatal childhood poisoning with methadone in the District of Columbia, and that antedated the introduction of child-proof medication bottles by the NTA. Induction of euphoria has been the intent of only a small minority (mean, 10%) of illicit methadone abusers.

In fact, the data suggest that the pattern of illicit methadone abuse is not simply a variation on the theme of heroin abuse. Rather, the majority of illicit methadone users (mean, 79%) report *treatment of their addiction* as their intent. The oral route of administration (mean, 92%) circumvents the morbidity and mortality of parenteral drug abuse. Methadone use is sporadic (mean, 16% use daily) and not closely associated with the underworld drug-distribution system. This is not to imply approval for the unsupervised use of methadone. This pattern is described simply to show that heroin abuse and methadone abuse are not synonymous.

An important consideration in interpreting the data presented is created by reporting results in percentages at a time when the size of the problem under investigation is declining. Thus, the rising proportion of respondents who report NTA as the origin of the methadone they purchase in the streets (Table 2) does not mean that diversion of methadone from NTA is increasing. Rather, such a trend is a consequence of eliminating the other major source of illicit methadone, ie, private physicians. This trend is more properly interpreted as NTA representing a growing proportion of a diminishing problem. In absolute terms, the amount of medication diverted from the treatment programs has declined substantially. Similarly, the reported decrease in friends and increase in dealers as distributors of illicit methadone in the most recent survey (Table 2) reflects the declining number of "friends" who are able and willing to supply others with methadone.

Once the magnitude of the methadone-abuse problem was appreciated, a concerted effort began to control the diversion of methadone. This effort involved local drug treatment officials, law enforcement officials, the medical society, and private practitioners of both medicine and pharmacy. Although it is difficult to prove a causal relationship between these control measures and the observed changes, the data presented above show that the magnitude of the illicit methadone problem has been reduced substantially. This reduction occurred in temporal association with measures intended to control a problem that one might have expected to worsen as a result of the heroin shortage. Methadone-overdose deaths are now an unusual occurrence. Rates of detection of methadone by urine screening, police seizures, and nonfatal abuse episodes have reached a minimum for the period of observation. Reported rates of illicit methadone use and availability have declined. These changes have followed from the community's determination to make the use of methadone as safe as possible. It must be noted that the *legitimate* use of methadone has declined during 1973, as the number of heroin addicts requiring treatment declined.

At least four major factors were associated with the decline of methadone abuse in the District of Columbia. First, the campaign undertaken to acquaint the residents of the city with the hazards of unsupervised methadone use and the publicity given methadone-related deaths were associated with a significant attitudinal change among drug users (Table 2). As time passed, a growing proportion of those interviewed expressed the opinion that methadone was at least as dangerous as heroin, if not more so. This change in attitude produced other problems (see below), but certainly did operate to reduce the likelihood of individuals being willing to abuse methadone.

Second, eliminating the use of methadone by physicians in the private sector who were not providing the close supervision and many ancillary services required for effective addiction treatment was a critical development. The conviction and imprisonment of the worst offender among these physicians was a major deterrent to his associates' methadone prescribing. This channel of diversion was finally sealed when the local medical and pharmaceutical professional societies voluntarily agreed to discontinue the use of methadone, making the treatment program the only legitimate source of the drug.

Upgrading of methadone clinic security and an improved methadone-distribution accounting system within NTA also enhanced control of methadone diversion from the clinics. Use of unit-dose medication, computerized monthly summaries of methadone distribution and utilization, and the installation of bars, alarms, and narcotics safes in those clinics dispensing and storing methadone simultaneously reduced methadone theft by breaking and entering and the potential for theft by unscrupulous clinic staff members.

Finally, modification of methadone take-home privileges was critical in reducing diversion by NTA patients. This policy change had two components. First, based on

the work of Goldstein and Judson,[17] it seemed that patients receiving high doses of methadone were a major potential source for medication diversion. Their observation that addicts were unable to distinguish between widely disparate doses of methadone above 60 mg/day suggested that those receiving higher doses could easily take part of their medication and sell the remainder. An NTA patient taking home anywhere from 100 to 160 mg of methadone a day could easily sell half of his medication. Thus, the maximum dose dispensed by NTA was reduced from 160 mg to 80 and, subsequently, 60 mg. At the same time, the number of doses of medication a patient was allowed to take home at one time was also reduced. Together, this produced a sharp reduction in the amount of methadone that was available for potential diversion. Second, the criteria that had to be met for a patient to obtain take-home privileges were made more stringent and were more strictly enforced. Thus, the likelihood of take-home medication leaving the clinic in the hands of an unstable patient was reduced. Together, these four control measures were associated with a sharp decline in the use of illicit methadone.

It is important to note that control of methadone abuse in Washington has been associated with several important problems. The attitudinal shift (mentioned above) among heroin users with respect to the dangers associated with methadone (Table 2) produced a community less supportive of the *therapeutic* use of methadone, and heroin users who are more reluctant to be treated with methadone. In addition, the reduction in methadone take-home privileges (a major component in the control of methadone diversion) has made NTA less attractive to the user in need of treatment. Not only are some users discouraged from enrolling in treatment, but many long-term patients accustomed to the more liberal take-home policy have left the treatment program. Evaluation of the rate with which patients left the treatment program (excluding those medically discharged) for the ten weeks prior to reduction of take-home frequency disclosed a mean dropout rate of 62 patients per week. During the ten weeks following this policy change, this rate increased significantly to 94 patients per week ($U = 26$, $P < .05$). The new regulations were frequently interpreted by the patients as repressive and restrictive. The severity of the methadone-abuse problem in the District of Columbia left treatment officials with very little choice in this matter, and the results of control measures have been gratifying. However, one must keep the impact of such measures on the treatment effort in mind, and make every effort not to compromise the effectiveness of the treatment programs. The needs of addicts requiring treatment must be weighed against the potential hazards to which the community is exposed. The two most important measurements in determining whether or not methadone availability is sufficiently well-controlled are rates of methadone overdose (fatal and/or nonfatal) and rates of primary methadone addiction. Our data suggest that annual methadone death rates of less than 1 per 100,000 general population are attainable and that rates of primary methadone addiction among opiate users can be less than 1%. High or increasing rates for either of these indicators should suggest the need for tighter control of methadone availability.

In conclusion, it is apparent that methadone has real abuse potential that can be the source of considerable morbidity and mortality in a community. Although the demand for illicit methadone appears to stem from its therapeutic rather than its euphoria-producing effect, the widespread availability of methadone in the illicit market has unacceptable social consequences. However, it is equally clear that one does not of necessity incur high social cost when methadone is carefully controlled and administered only in well-organized addiction treatment programs. The experience with this issue in Washington, DC, has shown that, once the problem was understood, it has become possible to use methadone in the treatment of large numbers of heroin addicts while minimizing the negative impact of methadone on the community at large. The positive impact of methadone in helping to curb the heroin epidemic in Washington has been previously reported.[15,16] We have discussed how one community weighed the relative importance methadone's impact in controlling heroin addiction vs the morbidity associated with its illicit use. We hope that our experience in learning how to minimize the negative consequences of methadone will help others to prevent these problems before they occur.

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DECRIMINALIZATION OF MARIHUANA

Mr. STOKES. Let me ask you this: I have occasion oftentimes to speak to many young people, and one of their most vigorous arguments when we have occasion to talk is that there is no evidence that marihuana is harmful or that it is addictive. Also, that since it is permissible for our generation to buy liquor, which they say is also a drug and addictive, they question why we continue to make either usage or sale of marihuana a crime. I would like to know whether or not you have any studies that respond to that argument.

Dr. DUPONT. Yes, sir. There is a report called "Marihuana and Health" which the Department of HEW submits to the Congress on an annual basis. I will be happy to get you a copy, with a summary of some of the evidence that shows the health hazards involved in smoking marihuana.

The most obvious one, that young people seem willing to accept, is the problem of intoxication itself. The effects on driving, for example, or the ability to work or study are not very different from those which people experience from using alcohol. These are temporary effects, but they are major effects as well.

In any event I think in dealing with these issues—and they tend to come from so many directions at once that it is hard to sort them out in a manageable way—is to recognize that there is a health issue and there is also a legal issue, and they are quite separable and distinct. As concerns the legal issue, it seems questionable to me that cancer rates, highway fatalities, or any similar phenomenon would justify making possession of marihuana a criminal offense. On the other hand, to make marihuana easily obtainable by legalizing its production and sale also seems injudicious. This is an important issue.

I would tend to separate the health and the legal problems and say that what we are looking for is a legal way to discourage marihuana use without incurring a high social cost from whatever discouragement policy we adopt. Using the criminal law is a very expensive way to discourage use of marihuana.

This is why, for example, the State of Oregon's use of noncriminal but legal sanctions against marihuana use has promised a way out of this dilemma. They have what I believe, is a fine system in Oregon. An individual found guilty of possessing marihuana is fined $25, but it is not judged a criminal offense. People are not prosecuted as criminals. They don't take up valuable court time, they aren't given criminal records, but society maintains its position that this represents undesirable behavior.

A study was made in Oregon, 1 year after this approach was adopted, which showed no increase in marihuana use in Oregon during the course of the year. That kind of evolution is now spreading across the country, and my hope is it will do something to take some of the emotionalism out of this issue and permit us to talk more rationally about it.

INCREASED USE OF MARIHUANA

I am concerned though, Mr. Stokes, with the rising levels of marihuana use. For example, a national survey of 23-year-old males, showed that 62 percent had used marihuana at least once. This wasn't

as terribly surprising, although it is a high percentage, as the fact that 10 percent were found to be daily users. This compared to 14 percent in the same group who were daily users of alcohol and 47 percent who were daily users of tobacco. All of the other drugs noted in the study were used on a daily basis by less than two/tenths of a percent of the population surveyed.

This made it evident that marihuana use has now reached a point where it is joining tobacco and alcohol as one of the most widely used substances in our society. I think we are just beginning to get some idea of what the problems involving marihuana are. The one I just pointed out is of great concern to me.

COMBINED DRUG AND ALCOHOL USAGE

Another point I think is important is that there has been some talk about the extent to which individuals are switching from alcohol to marihuana or marihuana to alcohol. The evidence is that these two substances are often used in conjunction; further, people who are heavy marihuana users tend to drink more, and vice versa.

What we have seen in this country over the last decade is an increase in the consumption of all of these drugs, not a switch from one to the other.

I am especially concerned about the results of the synergistic effects of marihuana and alcohol on such activities as work performance and driving performance. There is some evidence that the effects of these substances when combined are more serious than the individual aspects of either.

I think there is a reason for considerable concern about the rapid escalation of marihuana use in our society. It doesn't lead me to conclude we ought to lock people up for possession, but we ought to stop talking about marihuana as if it is a safe substance.

Mr. STOKES. I appreciate your treating the decriminalization aspect of it also because that was going to be my followup question. This is the next question the young people ask you.

Do we have any studies that relate to whether or not those who use marihuana graduate to other drugs and the other more serious forms of addiction?

Dr. DUPONT. The use of any drug substance has been positively correlated with an increased likelihood of use of other drug substances. As an example, the best predictor of subsequent marihuana use among young people is early use of cigarettes. Similarly, alcohol consumption is associated statistically with more marihuana and heroin consumption. That doesn't mean anyone who smokes cigarettes or drinks uses marihuana. However, it does mean there is an increased likelihood of this occurring.

I think the idea that there is one substance whose use will lead to experimentation with other drugs is not likely to be sustainable. But there is a sense that the increased use of any of these substances is likely to be associated with use of the others, and my sense is that diminished use of one will result in diminished use of all.

For example, there was a study done of returning Vietnam veterans that showed that the giving up of any drug substance positively correlated to the giving up of other drug substances.

In this arena, I think one thing we have to talk more about is the importance of two principles, and although Dr. Chafetz might disagree a little with my emphasis, I believe he would agree that for those people who choose not to use any of these substances, whether it be tobacco or heroin, we want to give them support in their decision to abstain, to encourage that behavior and provide them support for that choice among the peer groups to which they belong. We haven't done a very good job so far in providing such support to those individuals. That is one of the principles.

The other concerns the people who are abusing these substances. We need to help them to moderate their use, to persuade them to seek treatment, to emphasize the development of their own inner resources, their family resources and whatever resources are available, to help them become moderate users of whatever substance they are using.

Mr. STOKES. Earlier today, in response to someone's question, you mentioned the age category with reference to usage of alcohol and I think you said 12 to 17.

Dr. DUPONT. That was Dr. Chafetz.

ALCOHOL AND MARIHUANA USAGE

Dr. CHAFETZ. Mr. Stokes, I think that one of the spices of life is where you stand depends on where you sit. My colleague, Dr. DuPont, I respect, but I must say with complete candor that our studies are in contrast, that people who use marihuana—he is absolutely correct and it is confirmed by our studies—will tend to use alcohol. But in our studied young people, who tend to start using alcohol, only a third of them go to marihuana. But that is beside the point.

Dr. DUPONT. I don't disagree with that. I said those who do drink will be more likely to use marihuana than those who don't drink.

ALCOHOL AND YOUNG PEOPLE

Dr. CHAFETZ. OK. I think I would like to have you remember for dealing with young people—I think it is all wrong if we don't bother with them—they raise a false argument when they say marihuana is harmless. Any drug that has an effect on human beings is not harmless. I can kill you if I give you too much oxygen, too much water—rather necessary ingredients of life. That is false argument. Marihuana is not a harmless drug. The issue is relative risk.

I think what is troubling me is the fact that with young people using alcohol that doesn't surprise me. All societies that we know have their own ways of getting highs, whether it is through chemical agents, or religiosity, or interest in all kinds of things. That shouldn't surprise us.

The issue is whether or not the use of substances or mechanisms to get high is detrimental and destructive to them and society. I think that is where the real issue lies with young people.

This study I related to the committee shows that young people are overdosing with the drug alcohol at a high incidence. Our study further shows that by grade 10, 50 percent of them report using the alcohol at night in cars. We see that their death rate on the highway with heavy alcohol use in traffic fatalities is 50 percent higher than the rest of the population.

I think that is where the real issue comes. And the issue is not to terrify them and not to ban alcohol—we have had that horrible approach—but to recognize that perhaps by a communicative method along with various other systems we can begin to show them some respect and they can show some respect for themselves by learning if they choose to use it to use it in a responsible way as Dr. DuPont alluded to.

AGE GROUPS AND DRUG ABUSE

Mr. STOKES. In terms of a drug, narcotic problem or marihuana problem as such, what kind of studies do we have with reference to this similar kind of situation he describes, that is the age group in which they use drugs?

Dr. DUPONT. Our studies indicate there is a higher rate of use among younger people than among older, a higher rate in urban and suburban areas than in rural areas, and a higher rate on the west coast as compared to other areas of the country. The next highest area of use is on the east coast. These reflect general trends symptomatic of marihuana use.

There is a great deal in Dr. Chafetz' study which also included marihuana and other drug use as well. As you can see, there is a lot of information available about specific population groups and rates of use.

Mr. STOKES. Can I have that report, Dr. Chafetz?

Dr. CHAFETZ. Yes. The final report will be in momentarily and I will be happy to supply it to you.

DRUG AND ALCOHOL PREVENTION PROGRAMS

Mr. STOKES. I have one further question.

In terms of the purpose of your bureau your basic mission is prevention. Let me ask you what kind of preventive programs do we have as it relates to both kinds of drug addiction in our schools?

Dr. DUPONT. When you talk about drug abuse education in our schools, there are a number of issues which involve agencies beyond our own, particularly the Office of Education.

But basically what has happened—I think both with drugs and alcohol—has been an incorporation of a whole new body of information into the curriculum that all students are now exposed to. This represents a beneficial change that has happened within the last few years.

In this context, one of the findings in the drug area which has been particularly significant is the recognition that dysfunction or dangerous drugs use tends to be concentrated among those young people having a variety of other problems, such as problems with attendance, with grade performance, problems wtih peer groups, and so forth. The provision of human services programs to this group of young people has been shown to be one of the best ways to prevent the emerging sequence of drug problems, including the use of heroin or marihuana or alcohol. Dr. Chafetz may wish to comment on this.

PREVENTION OF ALCOHOLISM

Dr. CHAFETZ. The hour grows late and I promise I will be brief.

I think that one of the things we have done, Mr. Stokes, first of all we have an objective to promote awareness in young people—by the way, it is not a scare technique. I hope it is a respectable and respectful communication with all levels of society. But with the young people one of the ways we have developed our prevention program is to ask them what kind of program they could respond to.

My service in Government has led me to believe that one of the mistakes we make as a generality is that we decide what is right for everyone else, and our experience with the Indian alcoholism programs, where we had expertise in alcoholism but no expertise in what it feels like to be Indian, was to get them to tell us what is necessary for their people. And we view young people as having certain values and modes of communications that will be responsive to them if we bother to listen to them. They are helping us develop our curriculum programs from K–1 right into the university. We are going into the universities. They are advising us, and we have a very active and important campaign. I am very excited by its potential.

Mr. STOKES. Thank you very much, gentlemen. I have no further questions.

Mr. FLOOD. Mr. Michel.

REDUCTIONS IN ALCOHOLISM RESEARCH

Mr. MICHEL. Your budget anticipates reducing the funding for research grants and contracts by $2.7 million. How does the number of grants and contracts compare with last year and in what areas will you be reducing the research?

Dr. CHAFETZ. The 1976 budget anticipates a total reduction of 22 grants from the 1975 level. Biomedical research will decline by 10 awards, from 64 to 54, and psychosocial research awards are projected to decline by 12 awards, from 72 to 60. Research contracts will not decline in number.

Grants receiving their final award in 1975 represent a variety of topics in the biomedical and psychosocial areas and will reduce the overall institute effort in such areas of past interest as: liver function, blood and the circulatory system, individual psychopathology leading to alcohol abuse, and the role of alcohol in subcultures, ethnic groups, and families.

ALCOHOLISM INTRAMURAL RESEARCH

Mr. MICHEL. By adding 16 additional personnel to your intramural program, will you be able to take up some of the slack created by a reduction in the grants and contracts program?

Dr. CHAFETZ. The proposed increase of 16 intramural research personnel reflects the Institute's attempt to strengthen the biochemistry, behavioral, clinical, and neuroscience components of our intramural research program. By so doing, research into the cause-and-effect relationship of alcohol will be conducted with all the benefits of interacting with the intramural research efforts of other health institutes.

It is projected that 22 extramural research projects which would normally receive a competing award cannot be renewed in fiscal year 1976 due to the insufficiency of funds. These projects are in a diverse number of research subjects of long standing interest to the Institute. Obviously, new intramural research personnel will not have the specific experience necessary to continue the work previously conducted under the terminated extramural projects. Furthermore, the focus of the intramural programs will be geared toward objectives which are in concert with, but not duplicative of, extramural program efforts.

ALCOHOLISM RESEARCH PROJECTS

Mr. MICHEL. Last year you provided a list of 15 major reseach projects, the amount of money involved in each, and the general purpose of the project. Could you update that list for us in regards to the progress being made and for those projects which have been completed, what the final results were?

Dr. CHAFETZ. We'd be delighted to provide an update of the research projects for the record.

[The information follows:]

UPDATE OF INFORMATION ON FIFTEEN MAJOR ALCOHOL RESEARCH PROJECTS

The following is an update of the status of the major projects reported last year. The amounts indicate the last award made to the grant. In some cases, grants have not yet received their 1975 awards due to start dates late in the Fiscal Year. For each grant, an abstract of the research is shown followed by a brief statement of progress.

R01 AA00177 - Epidemiology of Alcoholism in Latin America----------($153,000)

This study of drinking patterns in ten Latin American sites is designed to determine the prevalence of alcoholism and heavy drinking in urban, semi-rural and rural settings as related to type of beverage, age, sex and cultural variables. Surveys in samples of the population, through questionnaires as well as the informant method, will be used. A Center for Studies on Alcoholism has been set up in Costa Rica. Two international seminars on traffic accidents and alcoholism will be held in two Latin American countries.

The Center for Studies on Alcoholism in Costa Rica is now established and important programs have been started in research, public education, training of health professionals and the prevention of alcoholism. Work continues on the development of the second center and the field work phase on the survey of drinking attitudes and behavior has been initiated.

R12 AA00209 - Washington University Alcoholism Research Center----------($370,489)

A broad range of projects are proposed for investigation: Aging, suicide, and alcoholism; a comparison between whites and blacks; alcoholism and criminality; a study of psychiatric illness in full siblings, half siblings, and adopted siblings of chronic alcoholic persons; genetic studies in alcoholism; state-dependent effects of alcohol in chronic alcoholic patients; psychological and physico-chemical correlates of alcoholic blackouts; sleep and growth hormone secretion in alcoholic individuals; effects of alcohol on hypnogenic brain areas in monkeys; effects of alcohol and the biogenic amines on volitional alcohol intake in animals and effects of chronic alcohol intake on the brain during critical periods in development; brain biochemistry in human alcoholism and in animals drinking excessively; effects of chronic alcohol administration on the enzymes involved in catecholamine metabolism in rats; an endocrinologic study of alcoholic men.

Because of the large scope and wide range of problems under investigation under the auspices of this Center, it would be difficult to report findings for specific studies. This Center is the most successful of the seven centers previously supported by the Center concept. During the seven years of its existence, 143 scientific publications have been published including papers dealing with the role of alcoholism in criminality, suicide, divorce, mortality, clinical services, educational achievement, learning memory and rearing of children. This research complex serves as a training site for research fellows, psychiatric residents, graduate students and medical students, and stands as a resource to assist other researchers in studying the problems of alcoholism.

R01 AA00232 - Socialization of Problem Behavior in Youth----------($10,000)

This is a longitudinal/cross-sectional study of the development of delinquency, aggression, use of drugs and of alcohol as related to socialization

processes, personality and social relationships. It will also study relationships of (1) alienation to opportunity perception, (2) deviance to socialization, (3) critical transition periods, and (4) adaptability to problem behavior. Study is arranged with controls for sex, social class and ethnic group. Data will be collected through questionnaires, teacher ratings, school records, sociometrics, interviews and factor analysis.

This project is virtually completed and some funds were provided to wrap up the project and to prepare it for publication in monograph form. Thus far 26 research reports have been written which report interim results as they become available. The comprehensive data analysis now underway will provide a social-psychological network which will account for a substantial portion of problem behavior variation.

R01 AA00239 - Effects of Alcohol on Liver and Intestine----------($108,792)

This is a project to study (1) effects of alcohol on lipid metabolism, (2) effects of ethanol of porphyrin metabolism and fatty acid oxidation, (3) effects of ethanol on intestinal transport, and (4) effects of ethanol on liver and intestinal cell membranes. Subjects are rats.

During the past year, studies carried out in chronic active hepatitis strongly suggests that liver damage is due to a lymphocytic cytotoxicity which leads to liver damage. In addition, the drug propranalol, used in treating hypertension, may inhibit the metabolism of alcohol.

R01 AA00256 - Psychiatric Illness in Adopted Children of Alcoholic Persons---------- ($71,463)

This investigator wishes to do a study of the male offspring of alcoholic persons who have been adopted and brought up by non-relatives. His thesis is that if alcoholism is genetic, a significantly higher number of these individuals will have problems with drinking alcohol than a control group. This study will use data gathered in the NIMH-Denmark study of schizophrenia. Subjects are male adoptees, born in Denmark between 1924 and 1947 (age 23-46) whose biological parents have been admitted to a Danish psychiatric facility and have been diagnosed as chronic alcoholic individuals. Controls are male adoptees whose biological parents had no overt psychopathology.

The data show that the sons raised by the alcoholic parents had essentially the same number of alcohol problems as did the sons who were adopted in infancy and raised by foster parents. Using specific criteria, about 25 percent of the adopted sons were described as alcoholic compared to 17 percent of the nonadopted sons, a difference that was not statistically significant. There was some evidence that as the severity of the alcoholism in the parents increased, there was an increased tendency toward alcohol problems in the sons. There was no significant correlation of length of exposure to the alcoholic parent and the development of alcohol problems.

R01 AA00267 - Alcohol and its Metabolic Effects----------($70,931)

This project is concerned with the metabolism of alcohol and thiamine deficient states. Subjects are adult and newborn rats and guinea pigs. The animal subjects are vitamin-depleted. Physical, chemical and microscopic examinations for cardiac hypertrophy, liver malfunction and brain damage are performed. Four groups of animals maintained under different regimens with reference to diet

and alcohol are compared. Another line of research uses radioactive techniques to study the metabolism of bilirubin.

The studies of the effect of liver disease on drug metabolism demonstrated that (1) parenchymal liver disease impairs the metabolism of some sedatives and antibiotics, (2) these drugs should be used cautiously in such patients, (3) some drugs (Serax, phenobarbital) are handled better than others (Valium) in patients with liver disease. These data show that the improper use of sedatives is increasingly incriminated as a precipitating cause of hepatic coma in patients with parenchymal liver disease.

R01 AA00287 - Effects of Alcohol on Subcellular Organelles of Liver----($186,450)

The objective of this study is understanding of the effects of acute and chronic alcohol consumption on mitochondria, endoplasmic reticulum, ribosomes, Golgi complex and limiting membranes of liver cells. In vitro studies will be done with cells isolated from the liver of mature rats given ethanol acutely or chronically for varying periods of time up to sixty days.

The last progress report for this grant lists eleven original contributions to the published scientific literature. The results of their research suggest that the subcellular organelles of the liver are almost all affected by chronic alcohol consumption, and that acetaldehyde (a by-product of alcohol metabolism) seems to mimic some of these effects. Some changes (such as those in the mitachondria and plasma membranes) appear to reflect damage, while other changes appear to be adaptive.

R01 AA00292 - The Enzyme-Substrate Compound of Catalase in Alcoholism--($281,687)

The object of this study is to identify the functional relationships of the components of the catalase pathway for ethanol and methanol oxidation at the molecular level and at that of the intact organ. Studies of catalase at the molecular level will seek to identify and to control the nature of the "peroxidatic" (alcohol-oxidizing) reaction. Heart and liver tissue are used. The ultimate objective is to develop treatment for the metabolic difficulties inherent in the alcoholic state.

Research on this grant continues to assess the relative importance of the several pathways of alcohol metabolism. Using highly sophisticated biophysical techniques, it would appear that the enzyme catalase contributes a small but significant part of this process.

R01 AA00297 - Zygotic and Uterine Mediated Effects of Alcohol-------(terminated)

This investigation consists of a number of studies on the effects of maternal intake of ethanol on reproductive physiology and on the post-natal development of off-spring reared by authentic and foster mothers. Subjects are inbred strains of mice with different levels of alcohol preference. Effects of ethanol on the mothers will be evaluated in terms of fertility and post-partum behavior. Effects on the off-spring will be assessed in terms of growth, sexual maturation, and various behavioral and endocrine measures.

Findings show that alcohol administered only via the mouse mother while the young are still in utero and/or during lactation produces changes in the metabolism, behavior and development of the offspring. Some of the changes affected by alcohol appear to be dependent on the endocrine system.

R01 AA00224 - Pathogenesis and Treatment of Alcohol-Induced Diseases---($209,032)

This is an interdisciplinary study of many facets of alcohol-induced liver injury. It includes investigations of (1) pathogenesis of cirrhosis, (2) early phases of liver injury, (3) the role of dietary factors in pathogenesis of liver injury, (4) the changes of structure and function of gastric mucosa, (5) intestinal absorption of alcohol, (6) hematological endocrine abnormalities of alcohol-induced disease, and (7) prevention and treatment of these disorders. Human subjects are alcoholics admitted to a hospital for treatment (sex and age not specified). Animal subjects are rats and monkeys.

Findings resulting from this grant indicate that alcohol itself may be toxic to the liver even though the alcoholized animal subjects were maintained on a balanced diet. Although the findings need to be corroborated by other researchers, this investigator reports the induction of the complete spectrum of alcohol related liver disease in the baboon.

R01 AA00380 - Women and Alcohol----------($98,493)

This study will address a number of questions that have been raised about women who are problem drinkers. Interviews with 200 women will take place as they enter treatment and again one year later. Approximately 100 sisters who do not have a problem with drinking will also be interviewed. The study women will be chosen from a variety of treatment settings in both urban and suburban areas; professional women and those from skid row or the homeless woman who is a problem drinker will also be interviewed. The study's objectives are to examine etiology, relationship of stress to drinking, effects and outcome of treatment.

Cooperating treatment agencies have been identified and interview schedules have been developed. During the first year, nearly 100 women and their sisters and husbands have been interviewed. This is almost half of the project number to be included in the study.

R18 AA00457 - Community-Reinforcement for Treating Alcoholic Persons-(terminated)

A community-reinforcement approach to the treatment of alcoholic persons was developed. This approach extended laboratory-derived principles and non-alcoholism applications to the problem of alcoholism treatment. Vocational, family and social reinforcers were arranged such that the alcoholic's new behavior patterns was incompatible with drinking. The comparison of the treatment modality with existing hospital procedure used a matched-pairs design. Outcome measures employed were time spent 1) sober, 2) employed, 3) with family, 4) non-institutionalized.

The results of this project are being prepared for publication in comprehensive form. The findings show that the treatment procedure which rearranged the significant community-based reinforcers of job and family and social life can substantially modify alcoholic behavior. Clients undergoing this treatment as compared to control subjects, (1) drank 5 times as little alcohol, (2) were employed 12 times as much, (3) remained with their family twice as much, and (4) were institutionalized 15 times less often. In addition, their earnings were twice as great as the control group. This study shows that a community-based treatment program can be extremely helpful in rehabilitating the alcoholic person on those measures having meaningful societal consequences.

R18 AA00493 - Problem Drinking of Urban Indians----------(terminated)

This study focused on the nature and extent of problem drinking of urbanized American Indians. Specific objectives included: 1) determine the quantity, frequency, context, and associated problems of Indian drinking in the city; 2) study the associations between Indian problem drinking and the demographic, social and psychological variables thought to be related to problem drinking; 3) compare Indian drinking problems with those of other urbanized ethnic groups (Black, Mexican-American, and Anglo) with similar socio-economic backgrounds; 4) investigate variations in drinking problems as a function of tribal affiliation; 5) determine changes in drinking behavior as a function of duration of stay in an urban environment. Data was gathered through formal interviews.

It is clear that there are major differences in drinking practices in the urban American Indian community as compared to American drinking practices in general. Although the overall proportions of drinkers are similar in the two populations, there are striking differences in the distribution of drinking practices with a much higher proportion of Indians in the Moderate and Heavy categories and a much lower proportion in the Light and Infrequent. It appears that if the urban Indian drinks alcohol, he is very likely to drink fairly heavily. The practice of drinking small amounts on infrequent occasions is somewhat atypical, particularly for Indian men.

R18 AA00498 - Clinical Studies of Alcohol Use and Abuse----------($552,359)

This inter-disciplinary research and education program will focus on clinical studies of alcoholism and alcohol abuse. Four major areas are delineated which encompass 15 individual projects:

I. STUDIES OF PSYCHOTHERAPY AND OUTCOME

A. Assessing Psychotherapeutic and Community Environments
B. Alcoholism: Future Oriented and Aversive Therapies
C. Group Psychotherapy with Alcoholics
D. Children of Alcoholic Parents: Effects - Intervention
E. Comparative Evaluation of Alcohol Treatment Programs

II. ADOLESCENT ALCOHOL PROBLEMS: DYNAMICS AND INTERVENTION

A. Alcohol Research on Adolescents
B. Adolescents and Alcoholism: Psychodynamics and Intervention
C. Alcohol and Aggressivity
D. Effects of Ethanol on Norms, Conformity and Status

III. BIOLOGICAL CORRELATES OF ALCOHOLISM PROBLEMS: IMPLICATIONS FOR TREATMENT

A. Sleep Indices and 5 hydroxytrytophan (5 HTP) Effects in Prognosis of Alcoholism
B. Brain Responses and Memory in Alcoholics
C. Biogenic Amines and Alcohol
D. Alcoholism - Genetic Aspects

IV. MULTIPLE-FUNCTION RESOURCES FACILITATING INTEGRATIVE STUDIES

A. Alcohol and California Offenders
B. Alcohol - Violence Clinic

The goal of the program is to elucidate the complex interactions of psychosocial and biological processes believed to underlie alcoholism.

Studies on the adrenocortical functions of animals bred for alcohol have revealed that the adrenal weights of short sleep animals were 25 - 30% heavier than those of long sleep animals. Short sleep animals which were much less affected by an acute effect of alcohol also showed more severe alcohol withdrawal reactions. In light of the recent report (1974a) suggesting that the adrenal corticosteroids play a permissive role in the development of CNS hypersensitivity seen during alcohol withdrawal, possibly through its effect in inducing tryptophan hydroxydase enzyme (1974b) further studies of the relationship of adrenocorticosteroids and alcohol dependence in these mice seem worthwhile.

R01 AA00688 - Alcohol Use During Pregnancy and Pregnancy Outcome--------($59,957)

The aim of this study is to determine if pregnancy complication or perinatal morbidity and mortality of infants is adversely affected by alcohol intake of the mother. The specific questions to be answered are whether prematurity rates, rates of stillbirths and abortions, neonatal mortality rates, rates of congenital defects are higher for drinking mothers than for non-drinking mothers. The four hospitals include a teaching hospital, two county hospitals and the Kaiser Health Plan Hospital serving a diverse population group. Analysis will be performed on many dependent variables taking into consideration the effect of such factors as parity, age, socioeconomic level, smoking and nutritional history.

Good progress on this grant is being made. During the first year of support data was collected on nearly 2,000 subjects. The goals for the second year are to complete the collection of data with some preliminary analyses to be started toward the end of the year.

NUMBER OF ALCOHOLICS IN THE UNITED STATES

Mr. MICHEL. How does the total number of estimated alcoholics in the country compare to the number last year? What percentage of those people are we now assisting through some kind of program?

Dr. CHAFETZ. In 1971 we estimated that there were 9 million persons with alcoholism and alcohol-related problems. In 1974 that number was 10 million. Further, the evidence indicates that the incidence of alcoholism increases during periods of economic stress so that we anticipate an increase in the number of alcoholic people during this year.

We estimate that about 8 percent of the Nation's alcoholic people are assisted annually by Institute-supported treatment programs. In addition, we believe that a significant number of people with alcohol problems, but who have not yet developed alcoholism, are aided as a result of the millions of contacts made through our prevention and public education programs. The Institute is currently developing the methodology for determining the extent of the population suffering from alcohol-related problems.

ALCOHOLISM AND YOUTH

Mr. MICHEL. How extensive is the problem of alcoholism among youth?

Dr. CHAFETZ. Alcoholic beverages are used by approximately two-thirds of our Nation's youth each year. The National Institute on Alcohol Abuse and Alcoholism is currently analyzing the results of a national probability study on the use of alcohol by U.S. teenagers who were in junior and senior high school during the spring of 1974. Preliminary results estimate over 15 million teenagers in school drank alcoholic beverages in the past year and of those at least 3½ million drink on a weekly or more frequent basis. This translates to 17 percent of school youth drink at what can be considered a heavy rate. Further examination of the data reveals that over 5 percent of the students, or over 1 million pupils, claim that they become drunk on at least a weekly basis. These figures are probably conservative due to the fact that grade school youth, sixth grade and below, and school dropouts were not included in the study. Several studies have shown that approximately 10 percent of the fourth through sixth grades drink on a weekly basis, and the school dropouts, estimated conservatively, drink at the same rates as those students who are currently in school. When these two groups are included in the total, an estimated 5 million youths between the ages of 9 to 18 years old, or one in every five youths, drink on a weekly basis.

COMPARISON OF ALCOHOL AND OTHER DRUG USE AMONG YOUTH

Mr. MICHEL. I have read several articles which suggest that alcohol is becoming an increasing problem among our young while the drug problem has leveled off and is even decreasing in some areas. Do you have any data in this regard?

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Dr. CHAFETZ. There are few studies which have measured the rate of illicit drug usage over time in specific areas of the country. It appears that specific drugs in one area of the country may be on the decrease, while drugs may be increasing in other areas. The only drug which has continued on the increase in the United States is marihuana. Alcohol usage among youths declined in the late 1960's while drug usage increased. There appeared to be a renaissance of alcohol abuse in 1971–72 when alcohol appeared to be supplementing drug usage. Noticeable today, however, is the rise of polydrug abuse, with marihuana and barbituate drug usage becoming more common, in combination with concurrent alcohol usage.

MINORITY GROUPS IN ALCOHOL PROGRAMS

Mr. MICHEL. You have targeted a number of different groups for special attention in the alcoholism program. Have we yet been able to concentrate our efforts toward any specific group or groups?

Dr. CHAFETZ. Yes; the Institute has targeted on a number of specific groups. In the treatment area, this concern has led to the development of specific programs serving special high risk populations. They include Indians, Alaskan Natives, public inebriates, drinking drivers, blacks, Spanish Americans, poverty groups, women, youth, the industrial work force, and the criminal justice population.

In terms of ethnic minority populations, the Institute estimates that the American Indian, Spanish American, black, poverty, and Alaskan Native projects benefited over 80,000 minority members in 1974, and this number should increase to about 100,000 in 1975.

Marked success has been experienced in several programs. In the Alaskan Native program, positive reductions in alcohol-related problems has been reported by a large number of the projects. Additionally, many of the villages have expressed an interest in seeking further information about how to initiate new programs. It is apparent that a growing recognition of the social problems of alcoholism and alcohol abuse is developing in Alaskan Native villages at least partially as a result of the programs.

In the Institute's Indian programs, prior to NIAAA efforts, Indians shunned Alcoholics Anonymous groups. Through the Institute's activities, however, about 100 Indian Alcoholics Anonymous groups have been established. About 50 percent of Indians now entering NIAAA projects are self-referrals, whereas initially the rate was near zero. Entire Indian communities and tribes have gained knowledge about alcoholism and its problems and, as a result, community resources have organized in a concerted effort to meet the needs.

Programs for blacks, Spanish Americans, women, youth, and criminal justice populations are new and we are not yet in a position to report on their progress.

With respect to poverty projects during the past year, these programs have stimulated unprecedented interest in alcoholism problems among the poor. They continue to identify various numbers of persons and families with alcohol-related problems in the poor community. Currently, the 190 active poverty projects have estimated caseloads of 300 clients per facility per year.

The drinking driver, public inebriate, and industrial alcoholism programs also received focused attention. These programs served an estimated 34,000 individuals in 1974, and the estimate for 1975 is 49,000.

The Institute's training endeavors, additionally, are conducted with a view towards the needs for manpower development and representation for those specific populations being served in the treatment programs.

ALCOHOLISM EDUCATION

Mr. MICHEL. What kind of an education program is used to provide information to groups such as teachers, clergy, attorneys, et cetera? How do you reach these people?

Dr. CHAFETZ. What we are attempting at the National Center for Alcohol Education, through training grants and in the area alcohol education and training programs, is to sensitize teachers, clergy, attorneys, and judges, among others, to the social health problems of alcohol abuse and alcoholism, and to gain their commitment to understand and to work with the problem.

The National Center for Alcohol Education is presently developing curriculum packages designed to be widely disseminated. These will enable gatekeepers like teachers and clergy to help youth in making responsible decisions concerning alcoholic beverages, and to aid them in identifying early problem drinking and to take appropriate action. Concurrently, extramural training grants support the development of professional training programs for teachers and clergy. The area alcohol education and training programs make stipends available for instruction programs of 6 months or more for these people.

ALCOHOL COMMUNITY PROGRAMS

Mr. MICHEL. With regard to alcohol community programs, you intend to decrease this funding by $25.8 million. Do you anticipate that support for this program will be picked up by any other sources?

Dr. CHAFETZ. The decrease to which you refer includes $6.4 million in the formula grant program. This represents an anticipated program reduction at the State level, although it is possible that in 1976 some of the States could contribute an increased amount toward programs previously supported by formula grant monies.

In the project grants area, existing grants will be paid at reduced levels to make up a deficit estimated at $7 million in the 1976 President's budget request. In addition, a large number of projects will have received their final year of Federal funding in 1975 and will not be continued in 1976. The ability of these projects to continue without further Federal funding varies depending upon the type of population served. Within nonpoverty populations, such as those served by the incentive contracts, occupational, and some of the alcohol treatment centers the prospects for third-party and other non-Federal financing are good. Institute efforts to bring about coverage by private insurers are assisted by an increasing consumer demand brought about by the influence of the projects, the employers of alcoholic individuals, and the benefiting communities. Nonpoverty projects can also expect a higher portion of their operating costs to be supported by patient fees. Within poverty areas, the strongest prospect without the passage of national health insurance, is the possibility that hospitals could contract with existing NIAAA-supported poverty and minority treatment facilities after the Federal grants expire. This latter arrangement could develop if the accreditation of hospitals requires the provision of alcoholism services in the communities served.

THIRD-PARTY PAYMENTS IN ALCOHOLISM PROGRAMS

Mr. MICHEL. What efforts are being made in NIAAA to increase third-party collections in alcoholism programs?

Dr. CHAFETZ. Special efforts are underway to generate sufficient State, local, and third-party funding support so that financing for alcoholism programs can come from local jurisdictions and from insurance payments on behalf of afflicted individuals. These efforts include the development of accreditation standards for alcoholism facilities in order to provide private insurance carriers with a set of standards on which insurance packages can be based. Additionally, credentialing standards to insure the provision of review by qualified, certified personnel have been developed. These have been distributed to the States and the Institute is currently engaged in encouraging the adoption of these standards by the States.

Other efforts include the development of a model insurance benefit package which seeks to demonstrate the economic feasibility of providing care for alcoholics in certain types of settings through the vehicle of the benefit package. Through the incentive contract program, the Institute is attempting to demonstrate the feasibility of outpatient programs designed to increase recovery of insurance benefits from the private insurance sector. Finally, the Institute is increasing technical assistance activities designed to upgrade the administrative, management, and programmatic components of the projects, and to assist grantees in obtaining other than Federal funds.

We anticipate that these efforts will help to replace the decreased level of Federal funding, although the outlook is not promising for many projects serving economically depressed areas or populations. For these projects, the best prospect without further Federal support is National Health Insurance.

OCCUPATIONAL ALCOHOLISM PROGRAM

Mr. MICHEL. Your efforts regarding the occupational alcoholism program will award a total of 40 projects in fiscal year 1976. How successful has this program been? I know of several programs being sponsored by companies back home in conjunction with labor organizations in this field. Has there been any major efforts nationwide by industry or labor to organize a comprehensive program?

Dr. CHAFETZ. Our efforts in the occupational field have been very rewarding. Some of this success has been due to the initiative undertaken by corporate management and others started by organized labor. Some of the most successful programs, however, are those in which the development came as a result of joint labor-management efforts. When an employee's job is endangered because of alcohol abuse, he has a strong incentive to take the appropriate remedial action offered. Institute-supported industrial alcoholism projects provide companies with identification and referral programs which facilitate the employee's efforts to overcome problem drinking.

An effective labor-initiated effort is being undertaken in Missouri under a grant from the Institute to the United Auto Workers. Under this grant, the United Labor Committee of Missouri, representing the AFL–CIO, Teamsters, United Auto Workers, and United Mine

Workers, is negotiating for their alcoholism program with corporate management as a fringe benefit. The programs, however, cover all workers, whether union members or not, and their families. Over 400 workers have already been helped, although the program has been established in most companies for only a few months.

Development of these programs once the decision to have one has been made is not a simple process. Staff must be hired, supervisors and shop stewards must be trained in their roles, and the work force must be made aware of the program and how it works. Results are not necessarily immediate. A nationwide effort is being undertaken to expedite this effort.

A number of major companies are developing programs in their installations throughout the country. A few of these programs go back a number of years, but the effort has been greatly accelerated since the creation of the National Institute on Alcohol Abuse and Alcoholism.

The institute, in 1972, offered each State a 3-year grant to provide them with two occupational alcoholism consultants. The institute trained these consultants to provide assistance to management and labor in the techniques of creating programs in private industry and in Government agencies. The 611 programs which we have been able to identify as having been developed in the last 3 years are due in large part to the efforts of these consultants. Most of these grants will end next month. However, the large majority of the States are continuing their occupational consultant capability. A number of States have noted the effectiveness of these programs which permit the identification of people in trouble with alcohol on the basis of their impaired work performance much earlier than has been possible in the past.

In summary, there are major efforts to organize comprehensive programs on a nationwide basis. This effort is not confined to the institute, however. Voluntary organizations, particularly the National Council on Alcoholism, and its affiliate local councils, through its labor-management committee, are making a major effort in this field. The cochairmen of the labor-management committee are George Meany and James M. Roche. Also indicative of the national character of this effort is the development of a national organization of persons working in this field. It is the Association of Labor-Management Administrators in Alcoholism, with headquarters in Atlanta and a membership of over 600.

ALCOHOLISM STATE FORMULA GRANTS

Mr. MICHEL. How are States using their formula grant funds?

Dr. CHAFETZ. It is estimated that two-thirds or 67 percent of total formula grant allocations are used for alcoholism treatment and rehabilitation programs. Approximately 8 percent is used for education, prevention, and training activities. The balance of funds are directed toward need surveys, model programs, State program development and administration, data collection, evaluation, and research.

DRUG TREATMENT CAPACITY

Mr. MICHEL. Last year, we were told that our capacity had developed to the point that all addicts who wanted help could get it and that the waiting lists had been eliminated. Are we still keeping up with the demand and do you anticipate we will be able to do so during the coming year?

Dr. DUPONT. During fiscal year 1975 our drug abuse treatment capacity of 95,000 treatment slots, which is capable of serving approximately 161,000 drug dependent individuals annually, achieved maximum utilization. Our data indicates that a similar phenomena is occuring in other Federal and non-Federal programs. In this effort, waiting lists have been reduced and most addicts who sought help were able to find it. However, growing evidence of a resurgence in drug abuse, coupled with the fact that our treatment network is operating at full capacity with little ability to reallocate or increase resources to community treatment services, means we can no longer be confident of remaining able to serve all persons in need of treatment services.

Mr. MICHEL. How is the institute going about shifting treatment slots from communities in which slots are underutilized to areas where there are unmet needs?

Dr. DUPONT. At the beginning of this fiscal year the institute initiated a quarterly review of all project grant and contract programs to more precisely match available funds with identified need. This involved reexamining each program to determine the actual level of utilization of funds in each, then reducing funding in programs with unused capacity and finally allocating any resultant savings to programs and communities with an unmet demand for treatment. In recent months our utilization rate has reached 100 percent and, consequently, there is no longer appreciable flexibility in this regard. However, periodic review of utilization rates is continuing and adjustments will be made, if possible.

THIRD PARTY PAYMENTS IN DRUG TREATMENT PROJECTS

Mr. MICHEL. You indicate the institute will be involved with the development and review of plans and recommendations on third party coverage of treatment costs. Realistically, what kind of possibilities are there in this area in promoting third party reimbursements?

Dr. DUPONT. Consistent with departmental policy and objectives, NIDA has developed an operational planning system to increase the level of third party reimbursements to drug abuse projects. Based on the analysis of information collected to date, however, it appears third party payments will represent only a small percentage of our drug abuse service projects' income in at least the immediate future. The reason for this is three-fold. Drug abuse clients are often lacking in employment status and/or employable skills which tend to preclude coverage under private group health insurance policies. Furthermore, while medicaid coverage is mandatory for the "categorically needy," many States have restricted coverage for the "medically needy" and administratively excluded the drug abuser. Second, traditional health insurance and medicaid generally recognize only services in the medical treatment model. The drug abuse treatment process emphases are nonmedically oriented facilities. Much of the service is aimed at the social, legal, and economic reintegration of the drug abuser into

society. Therefore, many private insurance plans either totally exclude drug abuse treatment or limit coverage to essential basic medical attention with very restricted aftercare. Finally, there are specific conformance requirements mandated by carriers for programs to achieve provider status. Such requirements may include licensing, accreditation, and demonstrated financial management capability, and certification of personnel. For the drug abuse service delivery system, these efforts are just beginning to evolve.

DECREASE IN DRUG ABUSE RESEARCH GRANTS

Mr. MICHEL. Research grants and contracts will be decreased by $2.3 million for fiscal year 1976, or 7 fewer grants and 14 fewer contracts than in fiscal year 1975. Do these 21 awards represent completed projects or what? In which specific areas will the decreases be, by dollar and by the number of awards?

Dr. DUPONT. The institute plans to make 14 fewer awards in 1976 with $2.3 million dollar reduction. This represents a reduction of 7 grants and 14 contracts. In 1976, the number of noncompeting and competing renewals will increase by 45 grants and contracts over the 1975 level. This increase is more than offset by a decrease of 59. This results in 14 fewer awards. In programmatic terms, the amounts involved are prorated across the various research activities so as to minimize the disruptive effects on any one area, while remaining consistent with current priorities.

RESEARCH IN TREATMENT TECHNIQUES

Mr. MICHEL. What research is being performed and/or will be initiated in fiscal year 1976 in the area of treatment, that is, substances which are substitutes for methadone and other drugs? Have we found any new ones which successfully block the effects of heroin?

Dr. DUPONT. Treatment research is continuing in a number of areas. LAAM, a long acting methadone substitute, is continuing to be developed under NIDA sponsorship. The phase II study, in which over 700 people received LAAM, is currently coming to an end, and planning has begun for phase 3, a large-scale clinical trial of this drug across the Nation. The final results of the phase 2 study will be available by later summer and it is hoped that the large scale clinical trial will be initiated by the fall, 1975. NIDA is also continuing the development of narcotic antagonists. Naltrexone is undergoing phase 2 development in 10 clinics with approximately 120 patients participating in studies. The collection of clinical information on naltrexone will continue throughout the next fiscal year as we begin planning for a large-scale clinic trial of this drug. NIDA has also initiated a cooperative clinical study of the use of darvon napsylate as a maintenance drug in the treatment of narcotic addiction. This will involve three clinics in a cooperative effort that is just now beginning. It is our hope that these drugs will eventually satisfy currently anticipated clinical needs. However, because one is never certain that a drug under development will be proven totally safe and acceptable for human use and because newer drugs seem to have certain potential clinical advantages, alternative narcotic antagonists are receiving initial evaluations. Among these drugs is diprenorphine which is planned to go into phase 1 of clinical testing in humans at the NIDA Addiction Research Center in Lexington in the near future.

INDICATORS OF DRUG AND ALCOHOL SUSCEPTIBILITY

Mr. MICHEL. In your studies of sociocultural family and personality variables to determine high risk groups, have you found any similarities in the factors contributing to the tendency toward alcoholism and the tendency toward drug abuse?

Dr. DUPONT. Studies conducted thus far have been of the correlates and predictors of drug and alcohol use in elementary and high school age populations. Those variables that are predictive of drug use are generally the same as those predictive of alcohol use, although these predictors show up earlier for alcohol than for drug use. It is possible to predict early onset of drinking by the 7th grade, whereas similar predictions for drug use are not possible until the 10th grade. We find that children displaying greater rebelliousness, lower academic achievement, greater approval of cigarette smoking, and less self-reliance and resourcefulness are most likely to become involved with alcohol or drug use.

One study in San Mateo, Calif., has shown that marihuana usage has about doubled from 1968 to 1973, while hallucingens, barbituates, and amphetamines have remained at the same level of usage. During the same time frame, alcohol usage rose from 72 percent to 83 percent. In Toronto, Canada, from 1969 to 1972 marihuana usage rose fivefold, but amphetamine usage declined slightly. Alcohol usage rose from approximately 48 percent to 67 percent during the same time.

PREVENTION PROGRAMS FOR YOUTH

Mr. MICHEL. Of the 48 prevention programs you are now sponsoring, how many are targeted toward youth? Could you expand on some of the efforts being made in this regard?

Dr. CHAFETZ. Thirteen of these projects are currently targeted toward youth. The Institute has funded a number of demonstration project grants designed to test the feasibility and effectiveness of different strategies in communicating with youngsters around the subject of responsible use and nonuse of alcohol. These grants utilize such approaches as peer modeling, teacher training, development of family communication skills, and school-community endeavors. In addition to these projects, the Institute supported a study which evaluated the impact of mass media in inducing our youth to seek information about alcohol. In addition to the demonstration grant activities, the Institute works with a number of national voluntary youth organizations including the YMCA, Boys' Clubs of America, the National PTA, Red Cross, and others.

ALCOHOLISM TRAINING GRANTS

Mr. MICHEL. In your justifications, you say you will support 29 additional clinical training grants, while reducing the amount of money for this account by almost $500,000. How can you accomplish this? Who will pay the bill for the difference?

Dr. CHAFETZ. The projected increase of 29 awards reflects the continuation of training grants initially funded with 1973 court-released appropriations. Since the initial awards were not made with regular 1975 appropriations, they do not show in the 1975 column of the budget.

The decrease in funding for 1976 indicates that continuation training awards cannot be paid at their full funding levels, due to an insufficiency of funds in the 1976 President's budget request. All commitments to students will be honored but funds to the trainee institutions will be reduced.

The Institute's training endeavors, additionally, are conducted with a view toward the needs for manpower development and representation for those specific populations being served in the treatment programs.

LONG TERM EFFECTS OF MARIHUANA

Mr. MICHEL. In light of the recent introduction of various bills in the Congress to legalize the use of marihuana to some degree, what progress has been made in your research on the long term effects and when might a report be available?

Dr. DUPONT. By law, each year the Institute prepares a report for the Secretary entitled "Marihuana and Health" which summarizes the current state of our knowledge and emphasizes the results of studies concerned with long term consequences of marihuana use. To date, investigations have been limited to a relatively small sample of users intensively studied in comparison with nonusers of similar background. We are now planning larger scale epidemiological studies both of American and overseas populations to further analyze possible health hazards in the use of this drug. To date, we do not have definitive answers to the questions posed by chronic use. It should be understood that frequently many years of exposure to a drug are required before the full implications of its use can be adequately understood. However, present investigations indicate that earlier reports on the harmlessness of this drug may have been optimistic. For example, there is now some evidence that heavy ingestion of marihuana may result in decreases in growth hormone in users.

WORK OF CLINICAL/BIOMEDICAL CENTERS

Mr. MICHEL. Could you provide a list of the eight clinical/biomedical centers and a summary of the major work being done in each?

Dr. DUPONT. Yes, sir; this data will be provided as an insert to the record.

[The information follows:]

THE EIGHT CLINICAL/BIOMEDICAL CENTERS FUNDED BY NIDA

The Addiction Research Laboratory, Stanford University - The work is directed toward five important investigations: the isolation of the opiate receptor, characterization of the time course of tolerance and physical dependence, elucidation of the biochemical mechanisms of opiate action, measurements of methadone in human plasma, and controlled clinical investigations of a number of aspects of methadone therapy.

The Drug Abuse Research Center, University of Michigan - This center is a cooperative effort to combine activities in five programmatic areas: the attempt to find a dependent-free analgesic and new morphine antagonists which are relatively free of agonist actions; a concern with reinforcement, with choice, and with correlations among behavioral, physiological, and biochemical consequences of drug-taking; the effects of narcotic analgesics and CNS stimulants on the uptake, storage, synthesis, release, and metabolism of 5HT dopamine and norepinephrine in the brain of rats and mice; the development of new methodology to quantitatively analyze drugs and their metabolites and endogenous substances; and the interaction of centrally acting drugs.

The Drug Abuse Research Center, Washington University (St. Louis, Mo.) - The objective of the St. Louis Center is to determine the extent and magnitude of the effects of narcotics on brain biochemistry and ultrastructure during the development of tolerance and physical dependence. The specific goal is to lay a foundation of basic information on the neurochemical and morphological effects of narcotics from which studies of the actual "mechanisms" involved in tolerance and dependence can logically progress.

Neurobiological Mechanisms of Adaptation to Drugs, University of California (La Jolla) - The purpose of this center is to study basic synaptic adaptive mechanisms in the CNS following the administrations of drugs of abuse, particulary amphetamines and morphine.

Johns Hopkins Drug Abuse Research, Johns Hopkins University - This center is concerned with basic studies in the following areas: amphetamines and brain catecholamines; biocehmical studies on opiate receptor mechanisms; interaction of drugs of abuse with neuroblastoma cells in tissue culture, morphological and neurophysiological studies of brain cholinergic neurons and their interaction with opiates, interaction of stimulant drugs and opiates in central neural systems, and behavioral pharmacology of narcotic antagonists in baboons.

Research Center: Studies of Drug Dependence and Abuse, University of Chicago - The range of research topics of past and proposed projects at this Center is extremely broad: effects of drugs of abuse on brain biogenic amines, the development of animal models for drug dependence, the study of morphine antibodies, the behavioral and perceptual effects

of drugs of dependence, studies of drug toxicity, adrenal hormone responses to stress in methadone maintained patients, the epidemiology of opiate addiction, and evaluation of clinical programs for abstinent and methadone maintained patients.

Center for Biobehavioral Studies in the Addictions, Harvard Medical School - The clinical research of this center involves a series of experimental analyses of drug acquisition in opiate addicts. The studies utilize the techniques of behavioral analysis developed by Mendelson and Mello in working with alcoholics, but are applied to marihuana acquistion in heavy and casual users.

Studies of Selected Narcotic Agonists and Antagonists, V.A. Hospital (Baltimore, Maryland) - This clinical program is comprised of three studies to evaluate various treatment modalities to treat narcotic addicts: a controlled double-blind study of the comparative effectiveness of naloxone, cyclazocine and placebo in the maintenance of parolled narcotic addicts; a double-blind controlled study of the relative safety and efficacy of methadone and L-alpha-actylmethadol (LAAM) in maintaining narcotics addicts; and a third study much like the first except that it will concentrate on youthful abusers and use only naloxone, not cyclazocine. In addition, therapeutic counselling, including family therapy, will be employed.

DRUG ABUSE MANPOWER REQUIREMENTS

Mr. MICHEL. You say that a total of 20,587 people received drug abuse training in fiscal year 1975 and that you expect 3,072 to receive training in fiscal year 1976. Do you have any estimates on what our total manpower requirements are in this area and how close we are to meeting that need?

Dr. DUPONT. Approximately 35,000 persons are employed in drug treatment programs. The annual estimated turnover or attrition rate is greater than 50 percent, or more than 17,500 treatment workers who are potential trainees. In addition, treatment service needs continue to increase at least 5 percent per year producing about 1,750 potential trainees. Recently, a number of Federal agencies, including Civil Service Commission, Department of Defense, Veterans' Administration, Bureau of Prisons, have expressed their training needs to NIDA. The total number needing training has not recently been estimated, but previous estimates exceed 10,000 workers. Continuing education must also be provided, especially considering that approximately 60 percent of current drug abuse workers are paraprofessionals who require specialized training for certification purposes.

Mr. MICHEL. How many educational institutions now offer a comprehensive training program in the drug abuse field?

Dr. DUPONT. As a result of NIDA support during the past 3½ years, twenty-eight institutions offering master's degrees now offer from one to five courses each in the field of drug abuse. In addition, 8 institutions offering bachelor's degrees have from two to five courses in drug abuse and 10 institutions offering associate of arts degrees have two or more courses for training students in matters dealing with drug abuse.

DRUG ABUSE EDUCATION PROGRAMS

Mr. MICHEL. Could you expand on any efforts being carried out to develop drug abuse education training programs? What types of programs are being supported by Federal dollars?

Dr. DUPONT. NIDA, through its national training system concept, is attempting to develop education/training programs on two levels. First we provide direct financial support and technical assistance to the States to aid them in the development of their capabilities to identify their training needs. Second, through the National Drug Abuse Center for Training and Resource Development, we provide direct training in limited number of specific areas as well as identify and validate existing resources on a nationwide basis. These efforts are in addition, of course, to the developmental training grant program, the career teacher program, and the research fellowship program.

STATEWIDE SERVICE PROGRAM CONTRACTS

Mr. MICHEL. Could you provide, for the record, a listing of the 26 States which will be supported by statewide service program contracts in fiscal year 1976 and a breakdown of how much money will be going to each?

Dr. DUPONT. Yes sir, this information is available and will be provided as an insert to the record.

[The information follows:]

Estimated fiscal year 1976 funds for statewide service contracts

State:	Amount
1. Arizona	$174,372
2. California	8,048,853
3. Colorado	745,044
4. Florida	324,966
5. Georgia	602,376
6. Illinois	1,042,269
7. Iowa	221,928
8. Louisiana	1,446,495
9. Maryland	305,151
10. Michigan	974,898
11. Minnesota	463,671
12. Missouri	491,412
13. New Jersey	3,907,518
14. New Mexico	313,077
15. New York State	9,622,164
16. New York City	2,873,175
17. North Carolina	217,965
18. Ohio	634,080
19. Oregon	931,305
20. Pennsylvania	546,894
21. South Carolina	396,300
22. Tennessee	202,113
23. Texas	3,689,553
24. Vermont	495,375
25. Virginia	832,230
26. Virgin Islands	126,816
Total	39,630,000

DRUG ABUSE TECHNICAL ASSISTANCE

Mr. MICHEL. What type of technical assistance is the Institute giving to grantees? Specifically, what technical assistance is being refunded in fiscal year 1976 at a cost of $777,000?

Dr. DUPONT. These funds will allow the Institute to extend its principal contract in this area through fiscal year 1976. This contract supplements the Institute's monitoring efforts by providing no-cost, on-site technical assistance to and review of treatment programs with specific and urgent needs as identified by the Institute. Assistance is specifically targeted to programs having difficulty complying with the Federal funding criteria for drug abuse treatment projects.

DRUG FORMULA GRANTS

Mr. MICHEL. How are States utilizing their drug formula grants?

Dr. DUPONT. A recent nationwide survey has shown that the States are utilizing their formula grant funds in approximately the following manner: (a) 13 percent for treatment and rehabilitation programs; (b) 45 percent for prevention and education programs; (c) 19 percent for training efforts; (d) 9 percent for research initiatives; (e) 4 percent for program evaluation; and (f) 10 percent for administration.

Mr. MICHEL. Does the Institute have a mechanism for monitoring the State programs and accessing their progress?

Dr. DUPONT. Presently, NIDA conducts a centralized review of each State's annual update of its State plan for drug abuse prevention. Our review committee consists of a six person ad hoc body representing various divisions and disciplines within the Institute. This review is

attended by a representative of the single State agency and the current status of the program is reviewed with the State representative. In addition, where funds permit, a NIDA program development specialist visits each State once between each year's review and the next year's submission. No other onsite monitoring or assessment is possible at the present time due to personnel and fiscal limitations.

DRUG ABUSE OUTREACH SERVICES

Mr. MICHEL. What type of outreach services are being performed by drug abuse projects?

Dr. DUPONT. Outreach activities have become limited within our programs as patient utilization has approached and finally reached 100 percent. Almost all efforts of grant and contract personnel are now focused on providing necessary treatment services. Very minimal outreach efforts are possible at this time.

DRUG ABUSE TRACKING SYSTEMS

Mr. MICHEL. You say that the integrated drug abuse management information system is currently in its initial design and developmental phase. What target date can you give us for when the system will be fully operational? How far are you in reaching agreements with all single State agencies?

Dr. DUPONT. The integrated drug abuse management information system (IDAMIS) as a viable drug abuse information system will be fully operational by October 1976. You may wish to know that the major component of the program, CODAP—the system for gathering basic patient utilization and demographic data—will be fully operational for Federal programs by the end of this fiscal year. In regard to State participation, at the present time all but two States have entered into systems development contracts with NIDA. Of the two remaining States, Massachusetts is presently negotiating for a contract and Vermont has had internal problems which have precluded their participation.

TOTAL FEDERAL EXPENDITURES ON DRUG ABUSE

Mr. MICHEL. Do you have any total figures available as to what the Federal Government through your Institute and other agencies such as the VA, the Justice Department, and the Defense Department is spending on drug abuse problems?

Dr. DUPONT. Our data indicates that the Federal Government spent approximately $517 million for drug abuse prevention activities in fiscal year 1974. It is estimated that this amount will decrease to $457 million in fiscal year 1975 and to $444 million in fiscal year 1976. Figures for our Institute, of course, range from $273 million in fiscal year 1974 to $220 million in fiscal year 1975 to the request before you for fiscal year 1976 of $222 million. The three other agencies with the largest budgets in this area are those you mentioned, the VA, Justice, and Defense. We estimate that they have spent or will spend in each year over this 3-year period respectively $30–33 million, $35–42 million, and $67–68 million.

MENTAL HEALTH RESEARCH

Mr. MICHEL. You are proposing a cutback of 223 research grants for fiscal year 1976. Do any of these grants represent completed projects?

Dr. BROWN. First, let me give the most direct answer and say yes, there are some research grant projects which will be completed this year and not funded in 1976. However, the decrease of 223 projects is a net change made up of several components. First, it includes a decrease of 149, representing projects to be completed this year. Second, it includes an increase of 183 in the number of first-year continuations attributable to competing projects which will be funded this year. The combination of these first two items gives you the net increase of 34 continuations which appears on page 19 of our justification. Third, the number of new and competing projects decreases by 257. The net result of all these changes gives you the decrease of 223 projects.

Mr. MICHEL. How can you justify such a substantial decrease in these particular areas?

Dr. BROWN. We would not justify the decrease on programmatic or professional grounds, Mr. Michel. Rather, the reduction is the result of economic necessity.

CHILD MENTAL HEALTH

Mr. MICHEL. How many projects and how much money will be focused on the problem of child mental health?

Dr. BROWN. This year, we expect to support 264 research grants and 10 hospital improvement projects, for a total research investment of $22,077,000. The 1976 budget would provide for 277 research projects and 5 hospital improvement projects, at a dollar level of $22,761,000. The slight increase is achieved through an internal redistribution of research grant funds.

Mr. MICHEL. You say that a major research focus of child mental health research has been in the area of childhood psychoses. What kind of progress have we made so far? Have we come up with any significant breakthroughs in this area?

Dr. BROWN. Progress in the complex area of child psychoses has been slow and hard won. Although considerable disagreement exists among investigators, some progress has been made in the important areas of classification and diagnoses, and in the identification of environmental, biochemical, and genetic factors involved in these illnesses. Much important work needs to be continued. Most promising has been an array of treatment modalities ranging from operant conditioning techniques to parent-oriented approaches in which the parents are the primary health providers in the treatment milieu. The effectiveness of some of these programs is being evaluated.

AGING AND MENTAL HEALTH

Mr. MICHEL. How much money is being directed to projects related to aging?

Dr. BROWN. During the current year we plan to support 18 research grants and 7 hospital improvement projects, for a total dollar investment of $1,875,000. In 1976, we are projecting 19 research grants and 4 hospital improvement projects, totaling $1,699,000.

Mr. MICHEL. What kind of input, if any, have you had in the development of the new National Institute on Aging under development at NIH? Do you see any areas of overlap in this regard?

Dr. BROWN. In 1974, several members of my staff participated in the work of the Department's Interagency Committee on Aging, which provided basic material for the final implementation plan for Public Law 93–296, Research on Aging Act of 1974. Concomitant with the appointment of the National Advisory Council on Aging, an Interagency Advisory Committee for Research on Aging has been established by the NIA. Two members of my staff have been appointed to membership on the new committee, which will assist NIA in development of the comprehensive plan for research on aging in DHEW required by Public Law 93–296. There are obviously possibilities for overlap in the social and psychological areas, but we hope that through the close inter-Institute collaboration we will be able to rule out needless duplication and strengthen research on aging by complementing each other's programs.

MULTINATIONAL STUDY OF SCHIZOPHRENIA

Mr. MICHEL. What is your contribution to the multinational study of schizophrenia being carried out in conjunction with the World Health Organization? Since the project was launched 7 years ago and was designed as a pilot study, what have we learned thus far?

Dr. BROWN. This study was designed to determine whether an international epidemiologic investigation of schizophrenia, which would require estimating the prevalence of this condition across many cultural settings, was feasible. As a study in psychopathology and in epidemiology, it is aimed at providing knowledge of the basic causes and nature of this presumably universal condition.

The pilot study has resulted in the development of an international standard method for diagnosis. We found that the method can be administered reliably across national settings and result in data which will make possible the comparison of the prevalence of psychosis across cultures. Field research centers have been established in nine countries. In investigating the nature and the course of schizophrenia in more than 1,200 patients across these nine national settings over a period of some 5 years, we learned several things.

First, a concordant group of schizophrenics, that is, having similar symptom patterns, can be identified in all centers. Second, a core set of symptoms appears to be common to schizophrenia regardless of the culture in which it is found. Third, certain types of schizophrenia appear to be more prominent in one culture than in the other. An example would be the high proportion of catatonic schizophrenia in Agra. Finally, the course of schizophrenia as regards the stability of certain symptoms, such as delusions of persecution, varies across national settings.

Of particular value to our knowledge of the causes and nature of this condition is the detailed systematic examination of patients having this diagnosis in various countries, thus contributing to our grasp of what may be critical to its nature and what may be shaped by the culture in which it exists. The body of data is invaluable in its elaborate, detailed characterization of the course of this most severe of mental disorders.

Finally, in establishing standard methods and field research centers in nine countries, the current program will make possible a series of refined epidemiologic, sociocultural and behavioral investigations in the future of great value to the U.S. and to other countries through the auspices of the WHO.

CRIME AND DELINQUENCY

Mr. MICHEL. In regard to the 44 homes which make up the project of the Center for Studies of Crime and Delinquency, where are these homes located and how many juveniles are involved in the project? What is the average number of juveniles residing in each home and what is the range—that is, how many are in the smallest home and how many in the largest?

Dr. BROWN. We have 3 in Arkansas, 1 in Colorado, 1 in Connecticut, 2 in Florida, 14 in Kansas, 3 in Maryland, 1 in Minnesota, 3 in Missouri, 1 in Nebraska, 8 in North Carolina, 2 in Ohio, 1 in Pennsylvania, 3 in Texas, and 1 in Ontario, Canada. The combined capacity of these homes is 352 juveniles. The average number in each home is 6 juveniles. The range is from the lowest of 5 in one home to 10 in another.

Mr. MICHEL. What is the extent of the juvenile problem? do you have any statistics available on the number of juvenile delinquents in the country?

Dr. BROWN. Nineteen percent or 258,112 of all arrests for serious crimes in 1973 involved persons under the age of 15, while 45 percent or 613,824 were under the age of 18. In a survey conducted by the Census Bureau, there were 48,050 adjudicated delinquents in juvenile facilities on June 30, 1971. These figures represent reported delinquency; self-report studies suggest that official statistics may reflect only about 10 percent of actual delinquent behavior.

Mr. MICHEL. How does the number of mentally disordered offenders handled on an average by the U.S. corrections system compare with other years?

Dr. BROWN. The Institute's estimate of 260,000 mentally disordered offenders was based on a 1965 survey of the number of persons handled by the American correctional system, including probation and parole. This survey was conducted by the President's Commission on Law Enforcement and Administration of Justice. Regretfully, comparable statistics have not been collected more recently.

Mr. MICHEL. How does the figure of 14,000 mentally disordered offenders confined in mental hospitals compare with other years and do you have a breakdown as to the types of crimes committed by these offenders?

Dr. BROWN. Statistics on the number of mentally disordered offenders confined in mental hospitals are not routinely collected. Data from a sample survey of admissions to State and county mental hospitals conducted for 1972 indicated that there were 11,748 admissions to security hospitals for mentally disordered offenders during the year. There were an estimated 14,000 adult mentally ill offenders admitted to mental hospitals, including correctional facilities, in 1967. This 1967 survey found the following admissions by type of offense: burglarly, larceny, and theft accounted for one-fifth of admissions; assault accounted for 14 percent; homicide for 11 percent; robbery for 10 percent and sex offenses for 9 percent.

51-805 O - 75 -- 39

MINORITY MENTAL HEALTH

Mr. MICHEL. You say that NIMH efforts in the area of minority mental health have included the funding of two national coalitions of mental health organizations? How much money is involved in the funding of each of these coalitions and how many people are involved?

Dr. BROWN. Currently, there are only two coalitions in operation—the Pacific Asian Coalition funded in the amount of $148,945 in September 1973 and the Coalition of Spanish Speaking Mental Health Organizations funded in the amount of $124,660 in November 1973. The former has a fiscal year 1976 continuation cost commitment of $236,000; the latter will be funded in the amount of $169,000 in fiscal year 1976. The Pacific Asian Coalition, with two full-time staff members in San Francisco, has organized coordinating committees in nine geographical areas, each with two representatives on the Board of Directors, and last year each area held a conference in which an average of 200 participated. The Coalition for Spanish Speaking Mental Health Organizations has established four regional offices—Los Angeles, San Antonio, Chicago, and New York—each with two staff members, has close to 60 member organizations, and has held four regional conferences with over 1,000 persons attending.

MENTAL HEALTH SERVICES RESEARCH

Mr. MICHEL. How much are you spending for services research?

Dr. BROWN. In 1975, we are spending $8,538,000, of which $818,000 will be for new and competing awards. In 1976, we are proposing $8,220,000, all of which would be applied to continuation costs.

HEALTH PLANNING

Mr. MICHEL. Have you had any input into the development of the new health planning activities?

Dr. BROWN. I assume that your question is directed at implementation of the National Health Planning and Resources Development Act of 1974, or Public Law 93–641. The Health Resources Administration has major responsibility for implementing the new programs under this legislation. ADAMHA staff has been meeting regularly with the Health Resources Administration staff to identify implementation issues of particular importance to alcoholism, drug abuse, and mental health programs. The purpose of these meetings is to give ADAMHA input as the regulations and guidelines for the program are being developed. In addition, a Departmentwide group chaired by the Acting Assistant Secretary for Health has been established to discuss and oversee procedural and substantive issues pertaining to implementation of the new Planning Act. The Acting Administrator of ADAMHA, is a member of this group.

HOSPITAL IMPROVEMENT PROGRAM

Mr. MICHEL. What are some examples of new methods of treatment which have been developed through the hospital improvement program?

Dr. BROWN. The HIP program has been designed to upgrade the quality of care in public mental institutions and has resulted in the introduction of new approaches of treatment in State mental hospitals. HIP grants have supported programs designed to increase the social activity of geriatric patients, to provide a therapeutic milieu across the hospital and to promote more consistent treatment of patients by hospital staff. In addition, HIP grants have been used to develop programs to screen admissions to the hospital, to prevent readmissions and to provide alternative living arrangements, such as group homes, for discharged mental patients.

MENTAL HEALTH INTRAMURAL RESEARCH

Mr. MICHEL. How many people are involved in your intramural research program? Does the emphasis in your intramural program differ from that in your extramural grant and contract awards?

Dr. BROWN. We have 373 permanent positions assigned to the intramural program. The program emphasizes laboratory-based research on such major disorders as schizophrenia and depression, as well as various childhood problems. We conduct a lot of basic research in the areas of brain function and behavior. Since the researchers and facilities are on our budget, we can redirect or fine-tune research efforts into areas we feel are promising. The extramural program awards grants to individuals who submit research proposals which have apparent scientific merit. The special advantage of the grant-supported extramural program lies in the fact that it gives us access to literally hundreds of outstanding researchers whose efforts and ideas might not otherwise have been developed. In a very special sense, the two programs are complementary.

MENTAL HEALTH MANPOWER NEEDS

Mr. MICHEL. Where do we stand in regard to the manpower necessary to meet the needs in the area of mental health? Is there a shortage of adequate hospital personnel?

Dr. BROWN. According to our most conservative estimates, we currently have sufficient manpower resources to meet the minimal needs of that portion of the Nation's population seriously requiring mental health care. However, we project future deficits for all categories of mental health professionals when these very conservative estimates are carried forward to 1981. These deficits, totaling over 37,000, reflect a very modest increase in the utilization of mental health services as a result of the impact of National Health Insurance; a low growth rate for the Nation's population; and maintenance of current production rates, adjusted for minimal rates of attrition from the existing pool.

Within this context, there are and will be increasing shortages of manpower to adequately staff hospitals providing care for the mentally ill. This need can only be partially lessened by the deinstitutionalization of certain types of patients to the community, where new demands will be made on available resources. In selected geographic areas and in certain manpower categories, shortages already exist for hospital personnel. In the case of psychiatrists, for example, this shortage will worsen if the flow of foreign medical graduates, who currently provide much of the service offered at such institutions, is reduced.

MENTAL HEALTH RESEARCH MANPOWER

Mr. MICHEL. Do we have an abundance of mental health researchers?

Dr. BROWN. There is presently no over abundance of mental health research manpower. Rather than focus primarily on the production of large numbers of researchers, however, the goal of the NIMH programs is to provide for the most effective utilization of current levels of available manpower and the selective development of categories of research manpower determined to be in short supply. This is consistent with recent legislation passed by the Congress and signed by the President in July 1974. Major problem areas for mental health research have been defined and we are working to mobilize the appropriate groupings of disciplines and interdisciplinary approaches to address these. Specific research training support, whether for individual or institutional awards, will be directly related to these disciplines and problem areas consistent with recommendations made to the Secretary, DHEW by the National Academy of Sciences as specified in the National Research Service Award Act of 1974.

COMMUNITY MENTAL HEALTH CENTERS

Mr. MICHEL. How many community mental health centers will have been funded in 1975 and 1976? How many additional centers will become operational in 1976? What do you anticipate will be the increase in the number of patients treated?

Dr. BROWN. By the end of 1975, we will have funded a total of 626 centers. Since no new awards are projected for next year, the 1976 total will be the same. By the end of 1976, 543 of these centers will have become operational. We expect the number of patients treated to increase from 1,482,000 this year to 1,698,000 in 1976.

MENTAL HEALTH TRAINING

Mr. MICHEL. In your justifications, you say that the Institute will work with approximately 1,600 grantees in the training area, providing technical assistance and consultation. How many staff people are involved in this operation.

Dr. BROWN. Approximately 91 persons have this function as part of their job. However, because relatively few of these 91 spend all of their time in this area, I would estimate the full-time staff equivalent of these people at about 50.

MENTAL HEALTH TECHNICAL ASSISTANCE EFFORTS

Mr. MICHEL. What type of technical assistance is provided to grantees?

Dr. BROWN. Technical assistance falls into three general categories: First, there is that provided to existing or prospective applicants for Federal support for mental health training, to acquaint them with the terms, procedures, goals, and priorities for competing for such support. Its purpose is to disseminate to the training community the Federal perspective on the state-of-the-art in mental health training, activities currently under way in ongoing projects from which they might benefit, and the accomplishments of previously supported projects. Second, there is consultative assistance to States, regions, and localities, in collaboration with Regional Offices and other appropriate Federal components. This concerns their mental health manpower planning, development, and utilization of resources related to the needs of their service delivery systems. Third, there is assistance through the collection and assessment of national manpower data and the conduct of special studies. This also includes the provision of technical assistance to States, local governments, service agencies, professional organizations and educational institutions on matters of manpower studies, program analysis, cost effectiveness, and program evaluation.

MONITORING RESEARCH GRANTS

Mr. MICHEL. What kind of monitoring is maintained with respect to the 640 projects awarded in the research grants area?

Dr. BROWN. Each research grant of the NIMH is monitored by a project officer with expertise in the particular area. One formal monitoring mechanism is the annual progress report, which is reviewed when the grantee applies for continuation funding for another year. Such reports include significant budgetary information, and summarize work on the project to date. They are supplemented throughout the year by publications and reprints. Equally important are site visits and personal contacts, which are made to the extent permitted by our operating budget. These provide the project officer with an opportunity to evaluate the project and the performance of staff.

Grantees also present their findings at scientific and professional meetings. This permits scrutiny of their work by the scientific community at large. Projects which recompete for funding, that is, beyond the 2 to 3 years typically recommended by scientific advisory groups submit even more detailed and thorough reports in justification for their applications for continued funding. These reports are reviewed not only by staff, but also by scientific experts who serve as consultants to the Institute.

Justification of the Budget Estimates

Appropriation Estimate

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH

For carrying out the Public Health Service Act with respect to mental health and, except as otherwise provided, the Community Mental Health Centers Act [(42 U.S.C. 2681, et seq.)] [1], the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, *as amended*, [2] the Narcotic Addict Rehabilitation Act of 1966, and the Drug Abuse Office and Treatment Act of 1972, [$781,358,000] *$653,627,000*. [3]

For "Alcohol, Drug Abuse, and Mental Health" for the period of July 1, 1976 through September 30, 1976, $129,855,000. [4]

Explanation of Language Changes

1. This change would delete superfluous language.

2. The citation of this Act is changed to reflect the enactment of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974.

3. Of the requested amount, $174,280,000 is dependent on authorizing legislation to be proposed for fiscal year 1976.

4. This language permits implementation of the Congressional Budget Act of 1974 which changes the beginning of the fiscal year to October 1. Of the requested amount, $33,930,000 is dependent on authorizing legislation to be proposed for the period of July 1, 1976 through September 30, 1976.

Department of Health, Education, and Welfare

Alcohol, Drug Abuse, and Mental Health Administration

Amounts Available for Obligation

	1975 Estimate	1976 Estimate
Appropriation	$795,608,000	$653,627,000
Comparative transfers to:		
"Departmental Management", OS for support of 1 position and $27,000 for Public Affairs, $3,000 for costs of OS audiovisual Management Information System	-30,000	---
"Office of Assistant Secretary, Health" $5,000 for costs of Automated Terminal System (ATS)	-5,000	---
"Health Services Administration" 1 position for health unit nurse, and 2 positions for Federal Employee Alcoholism Program	---	---
Comparative transfers from:		
"Health Resources Administration" for support of 4 positions and $63,000 for Upward Mobility	+63,000	---
Subtotal, budget authority	795,636,000	653,627,000
Unobligated balance, start of year	+13,774,000	---
Unobligated balance transferred from other accounts	+7,522,000	---
Total, obligations	816,932,000 1/	653,627,000

1/ Excludes $37,652,000 in FY 1973 appropriation restorations.

Summary of Changes

1975 Estimated obligations	$816,932,000
1976 Estimated obligations	653,627,000
Net change	-163,305,000

	1975 Base Pos.	1975 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Within-grade increases			---	+811,000
2. One extra day of pay			---	+160,000
3. Annualization of 1975 pay raise costs			---	+635,000
4. Annualization of 1975 position increase			---	+400,000
5. Increased payment to Office of Federal Employees' Compensation			---	+4,000
6. Increased payments to other accounts:				
a. DHEW Working Capital Fund			---	+486,000
b. Health, Service & Supply Fund			---	+101,000
7. Increased postage charges			---	+290,000
8. Increased Federal tele-communication service charges			---	+55,000
9. Increased payments to General Services Administration for rental costs			---	+989,000
Subtotal				+3,931,000
B. Program:				
1. Drug Abuse:				
a. Project grants & contracts	---	122,000,000	---	+15,962,000
2. Alcoholism:				
a. Research direct operations	10	487,000	+16	+725,000
Subtotal			+16	+16,687,000
Total Increases			+16	+20,618,000

	1975 Base Pos.	1975 Base Amount	Change from Base Pos.	Change from Base Amount
Decreases:				
A. Program:				
1. General Mental Health:				
a. Research grants	---	$72,519,000	---	$-13,020,000
b. Training	---	93,952,000	---	-48,552,000
c. Construction	---	28,024,000	---	-28,024,000
d. Staffing	---	172,053,000	---	-36,690,000
e. Child Mental Health	---	26,844,000	---	-2,064,000
f. Management & Information	490	19,499,000	-97	-541,000
2. Drug Abuse:				
a. Research grants and contracts	---	31,381,000	---	-2,383,000
b. Training	---	13,787,000	---	-10,787,000
c. Management and Information	295	15,097,000	-2	-1,328,000
3. Alcoholism:				
a. Research grants and contracts	---	10,522,000	---	-2,713,000
b. Training	---	7,540,000	---	-582,000
c. Community Programs:				
(1) Project grants and contracts	---	64,908,000	---	-19,457,000
(2) Grants to States	---	52,000,000	---	-6,400,000
d. Management & Information	125	10,330,000	-21	-3,651,000
4. Program Direction	301	10,459,000	-2	-209,000
5. Buildings & Facilities	---	7,522,000	---	-7,522,000
Total, Decreases			-122	-183,923,000
Total, net change			-106	-163,305,000

Explanation of Changes

Increases:

A. Built-in:

1. Within-grade increases: An increment of $811,000 for normal periodic within-grade advances are distributed as follows: $178,000 for General Mental Health Research Direct Operations and $239,000 for Management and Information; $52,000 for Drug Abuse Research Direct Operations and $143,000 for Management and Information; $3,000 for Alcohol Research Direct Operations and $52,000 for Alcohol Management and Information; and $144,000 for Program Direction.

2. One extra day of pay: An increase of $160,000 will provide pay costs for an extra day of pay. This increase is distributed as follows: $28,000 for General Mental Health Research Direct Operations and $41,000 for Management and Information; $9,000 for Drug Abuse Research Direct Operations and $25,000 for Management and Information; $1,000 for Alcohol Research Direct Operations and $9,000 for Management and Information; and $47,000 for Program Direction.

3. Annualization of 1975 pay raise: An increase of $635,000 will provide full year funding of the October, 1974 pay raise. This increase is distributed as follows: $145,000 for General Mental Health Research Direct Operations and $200,000 for Management and Information; $14,000 for Drug Abuse Research Direct Operations and $77,000 for Management and Information; $22,000 for Alcohol Research Direct Operations and $43,000 for Management and Information; and $134,000 for Program Direction.

4. Annualization of 1975 position increase: A net increase of $400,000 results from increases of $280,000 for Drug Abuse Management and Information and $360,000 for Alcohol Management and Information which are offset by decreases of $50,000 for General Mental Health Research direct operations and $100,000 for Management and Information, and $90,000 for Drug Abuse Research direct operations.

5. Increased payments to the Office of Federal Employees' Compensation: Payments will increase $4,000 in FY 1976. This increase appears in General Mental Health Management and Information.

6. Increased payments to other accounts: A total increase of $587,000 is requested to support central service costs provided to the Agency by the Health Services and Supply Fund ($101,000) and the DHEW Working Capital Fund ($486,000). These items appear in General Mental Health Management and Information.

7. Increased postage charges: An increment of $290,000 is requested to cover increased costs of postage services provided to the Agency. This increase is reflected in General Mental Health Management and Information.

8. Increased Federal Telecommunication System Charges: An increment of $55,000 is required to cover increased costs of telephone services provided to the Agency. This is included in General Mental Health Management and Information.

9. Increased payment to GSA for rental costs: The increase of $989,000 will be used to pay building rental costs for buildings occupied by Agency staff. This is funded under Program Direction.

B. Program:

1. Drug Abuse:

a. Community Programs Project Grants and Contracts: The increase of $15,962,000 reflects the funds necessary to maintain the 95,000 treatment slots funded in FY 1975. The increased cost in FY 1976 results from the fact that FY 1974 money was used to fund the cost of 1975 treatment slots, thereby reducing the 1975 base.

2. Alcoholism:

a. Research Direct Operations: The program increase of $725,000 will be used to support 16 additional positions. This will create a viable Alcoholism Intramural Research effort.

Decreases:

A. Program:

1. General Mental Health:

a. Research Grants: This reflects a reduction in research efforts of $13,020,000.

b. Training: This decrease of $48,552,000 reflects the phase-out of NIMH training programs.

c. Construction: This decrease of $28,024,000 reflects the phase-out of programs funded under the CMHC Act.

d. Staffing: This decrease of $36,690,000 results from a reduction in continuation costs. No new awards are proposed.

e. Child Mental Health: This reduction of $2,064,000 also reflects a reduction in continuation costs. No new awards are proposed.

f. Management and Information: This program reduction of $541,000 results from a reduction of 20 man-years of effort in the staff supporting NIMH programs.

2. Drug Abuse:

a. Research Grants: This reflects a reduction in research efforts of $2,383,000.

b. Training: The decrease of $10,787,000 reflects the continued phase-out of drug abuse training grants as well as the elimination of the Regional Training Centers.

c. Management and Information: A reduction of $1,328,000 results from a reduction of two positions as well as a reduction in the level of contracts administered by the Institute.

3. Alcoholism:

a. Research: This reflects a reduction in research efforts of $2,713,000.

b. Training: This decrease of $582,000 reflects the phase-out of NIAAA training programs.

c. Community Programs:

(1) Project Grants and Contracts: This represents a reduction of $19,457,000 below the 1975 appropriation level.

(2) Grants to States: This represents a reduction of $6,400,000 below the 1975 appropriation level.

d. Management and Information: This program reduction of $3,651,000 reflects a reduction in the level of contracts administered by the Institute, as well as a decrease of 21 positions.

4. Program Direction: This decrease of $209,000 represents a reduction to the overall funding levels provided to the Office of the Administrator and the Regional Offices staff, as well as a reduction of two positions.

5. Buildings and Facilities: Most of the funds in this account are used to repair the facilities of Saint Elizabeths Hospital. Funding for repairs and renovations to the Hospital will be proposed upon completion of the transfer to the District of Columbia.

Obligations by Activity

	1975 Estimate Pos.	Amount	1976 Estimate Pos.	Amount	Increase/Decrease Pos.	Amount
General Mental Health:						
Research	373	$92,908,000	373	$80,189,000	---	$-12,719,000
Training	---	93,952,000	---	45,400,000	---	-48,552,000
Community Programs:						
Construction of Centers	---	28,024,000 2/	---	---	---	-28,024,000
Staffing of Ctrs.	---	172,053,000	---	135,363,000	---	-36,690,000
Child Mental Health	---	26,844,000	---	24,780,000	---	-2,064,000
Management & Information	490	19,499,000	393	20,274,000	-97	+775,000
Subtotal	863	433,280,000	766	306,006,000	-97	-127,274,000
Drug Abuse:						
Research	102	34,000,000	102	31,602,000	---	-2,398,000
Training	---	13,787,000	---	3,000,000	---	-10,787,000
Community Programs:						
Project Grants & Contracts	---	122,000,000	---	137,962,000	---	+15,962,000
Grants to States.	---	35,000,000	---	35,000,000	---	---
Management & Information	295	15,097,000	293	14,294,000	-2	-803,000
Subtotal	397	219,884,000	395	221,858,000	-2	+1,974,000
Alcoholism:						
Research	10	11,009,000	26	9,047,000	+16	-1,962,000
Training	---	7,540,000	---	6,958,000	---	-582,000
Community Programs:						
Project Grants & Contracts	---	64,908,000	---	45,451,000	---	-19,457,000
Grants to States.	---	52,000,000	---	45,600,000	---	-6,400,000
Management & Information	125	10,330,000	104	7,143,000	-21	-3,187,000
Subtotal	135	145,787,000	130	114,199,000	-5	-31,588,000
Building & Facilities	---	7,522,000 2/	---	---	---	-7,522,000
Program Direction	301	10,459,000	299	11,564,000	-2	+1,105,000
Total	1,696	816,932,000 1/2/	1,590	653,627,000	-106	-163,305,000

1/ Does not include $37,653,000 in 1973 released funds.
2/ Carryover balance of $13,774,000 for CMHC construction and $7,522,000 for Buildings and Facilities.

Obligations by Object

	1975 Estimate*	1976 Estimate	Increase/Decrease
Total number of permanent positions	1,696	1,590	-106
Full-time equivalent of all other positions	308	308	---
Average number of all employees	1,922	1,894	-28
Personnel compensation:			
Permanent positions	32,095,000	33,374,000	+1,279,000
Positions other than permanent	2,570,000	2,607,000	+37,000
Other personnel compensation	718,000	696,000	-22,000
Subtotal, personnel compensation	35,383,000	36,677,000	+1,294,000
Personnel Benefits	3,768,000	3,864,000	+96,000
Travel & transportation of persons	2,177,000	2,147,000	-30,000
Transportation of things	79,000	79,000	---
Rent, communications & utilities	4,994,000	6,308,000	+1,314,000
Printing & reproduction	1,171,000	1,165,000	-6,000
Other services	23,428,000	16,484,000	-6,944,000
Project contracts	75,044,000	63,637,000	-11,407,000
Supplies and materials	2,023,000	2,009,000	-14,000
Equipment	1,194,000	1,498,000	+304,000
Grants, subsidies & contributions	667,671,000	519,759,000	-147,912,000
Total obligations by object	816,932,000	653,627,000	-163,305,000

* Excludes 1973 released funds of $37,653,000.

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action taken or to be taken
1975 House Report	
General Mental Health, Drug Abuse and Alcohol Training:	
1. The Committee rejected the proposed phase-out of ADAMHA training programs adding funds to support professional and paraprofessional manpower (pages 49-50 of the Report).	1. The training programs will be supported in accordance with Congressional intent in FY 1975. Phase-out of training programs is proposed for FY 1976.
General Mental Health Management and Information:	
2. The Committee supported the restoration of 226 positions and provided support for these people (page 49 of the Report).	2. The FY 1975 budget reflects the restoration of these positions. However, 27 positions were eliminated as a result of the 2% reduction in overall Federal employment.
Alcohol Community Programs:	
3. The Committee rejected the phase-out of the Alcohol Project Grants and Contracts Program stating that the health insurance industry was not prepared to absorb the cost of these programs (page 51 of the Report).	3. New and competing awards will be funded from the FY 1975 appropriation. The 1976 budget limits support to projects with existing Federal commitments.
1975 Senate Report	
General Mental Health, Drug Abuse and Alcohol Training:	
1. The committee rejected the phase-out of the training program expressing concern that withdrawal of support to Universities and Medical Schools would reduce the Nation's training capacity (page 73 of the Report).	1. The training programs will be supported in accordance with Congressional intent in FY 1975. Phase-out of training programs is proposed for FY 1976.

Authorizing Legislation

Legislation	1976 Authorized	1976 Appropriation Request
Public Health Service Act:		
Section 301:		
Research		
General Mental Health	Indefinite	$ 80,189,000
Drug Abuse	Indefinite	31,602,000
Alcoholism	Indefinite	9,047,000
Management and Information		
General Mental Health	Indefinite	20,274,000
Drug Abuse	Indefinite	14,294,000
Alcoholism	Indefinite	7,143,000
Program Direction	Indefinite	11,564,000
Drug Abuse Training		
Training Contracts	Indefinite	2,000,000
Drug Abuse Community Programs		
Project Grants & Contracts	Indefinite	600,000
Section 303 - Clinical Training Grants		
General Mental Health	Indefinite	30,266,000
Drug Abuse	Indefinite	803,000
Alcoholism	Indefinite	6,067,000
National Research Service Award Act:		
Section 472 - Research Training Awards		
General Mental Health	1/	15,134,000
Drug Abuse	1/	197,000
Alcoholism	1/	891,000
Community Mental Health Centers Act:		
Section 224 - Continuation of CMHC Staffing Grants - General Mental Health	Sums necessary	135,363,000
Section 271 - Continuation of Children's Services Grants - General Mental Health	Sums necessary	24,780,000
Section 261 - Funding Authorization for Continuation of Section 242 Alcohol Staffing Grants and Section 251 Drug Abuse Staffing Grants		
Alcohol Project Grants & Contracts	Sums necessary	10,431,000
Drug Abuse Project Grants & Contracts	Sums necessary	10,236,000
Drug Abuse Office and Treatment Act:		
Section 409 - Grants to States	1/	35,000,000
Section 410 - Special Project Grants & Contracts	1/	126,126,000
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act:		
Section 301 - Grants to States	80,000,000	45,600,000
Section 304 - Implementation of Uniform Act Alcohol Project Grants & Contracts	13,000,000	2,500,000
Section 311 - Grants & Contracts for the Prevention and Treatment of Alcohol Abuse and Alcoholism	95,000,000	32,520,000
Narcotic Addiction and Rehabilitation Act:		
Section 607 - Appropriation to Carry Out the Provision of the Act		
Drug Abuse Project Grants & Contracts	Sums necessary	1,000,000

1/ Authorizing legislation to be submitted.

51-605 O - 75 -- 40

Alcohol, Drug Abuse, and Mental Health

Appropriations History

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1966	$278,669,000	$278,669,000	$283,169,000	$283,169,000
1967	305,115,000	310,119,000	315,619,000	315,619,000
1968	346,909,000	296,909,000	346,909,000	346,909,000
1969	364,939,000	342,439,000	364,939,000	350,439,000
1970	357,904,000	360,302,000	385,000,000	360,302,000
1971	346,656,000	371,738,000	456,738,000	389,238,000
1972	499,451,000	581,201,000	658,201,000	612,201,000
1973	603,719,000	803,823,000	911,525,000	803,823,000
1974	1,281,731,000	795,475,000	845,475,000	815,975,000 1/
1975	692,190,000	761,601,000	811,114,000	795,636,000
1976	653,627,000			

1/ Includes $26,874,000 withheld in accordance with Public Law 93-192.

Justification

Alcohol, Drug Abuse, and Mental Health Administration

	1975 Estimate*		1976 Estimate		Increase/Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation & Benefits...	1,696	$39,151,000	1,590	$40,541,000	-106	+$1,390,000
Other Expenses.....	---	777,781,000	---	613,086,000	---	-164,695,000
Total, Obligations.	1,696	816,932,000	1,590	653,627,000	-106	-163,305,000

General Statement

The basic mission of the Alcohol, Drug Abuse, and Mental Health Administration is to develop knowledge, manpower, and services to prevent mental illness, to treat and rehabilitate the mentally ill, and to prevent the abuses of drugs and alcohol.

The Agency's FY 1976 budget request portrays this mission in both programmatic and functional terms. Programmatically, the appropriation is divided according to its three major areas of responsibility: general mental health, drug abuse, and alcoholism. Each of these broad programmatic areas is, in turn, divided functionally into research, training, and services. Within each function, priorities, needs, and approaches to these needs are addressed in specific programmatic terms.

The budget request for Alcohol and Mental Health community programs reflects the philosophy that the Federal role should be limited to demonstrating the feasibility of service models. Funds requested will be used to support projects with existing Federal commitments. ADAMHA will continue to fund the 95,000 drug abuse treatment slots which were supported in FY 1975 although at an average 8% lower Federal share of support. In each of these programs, therefore, greater reliance will be placed on income from third party payments, and state and local contributions. Accordingly, technical assistance efforts will continue to receive high priority within the Institutes to increase the availability of non-federal sources of support. The FY 1975 and FY 1976 funding levels proposed for the Agency's major programs are set forth in the following table:

	1975 Estimate*	1976 Estimate	Increase/ Decrease
General Mental Health.....	$433,280,000	$306,006,000	$-127,274,000
Drug Abuse.....	219,884,000	221,858,000	+1,974,000
Alcoholism.....	145,787,000	114,199,000	-31,588,000
Buildings and Facilities.....	7,522,000	---	-7,522,000
Program Direction..	10,459,000	11,564,000	+1,105,000
Total.....	816,932,000	653,627,000	-163,305,000

* Excludes $37,653,000 in FY 1973 appropriation restorations.

I. General Mental Health

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and benefits.....	863	$22,234,000	766	$22,388,000	-97	+$154,000
Other expenses.....	---	411,046,000	---	283,618,000	---	-127,428,000
Total.....	863	433,280,000	766	306,006,000	-97	-127,274,000

Authority:
Research: Public Health Service Act, Section 301.
Training: National Research Service Award Act of 1974, Section 472; and and Section 303, Public Health Service Act.
Community Programs: Section 224 and 271, Community Mental Health Centers Act (continuation costs): New authority expired.
Management and Information: Public Health Service Act, Section 301.

This major grouping of activities encompasses all programs of the National Institute of Mental Health. The 1975 and 1976 funding levels for the Institute's major program areas are set forth in the following table:

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research.....	373	$92,908,000	373	$80,189,000	---	-$12,719,000
Training.....	---	93,952,000	---	45,400,000	---	-48,552,000
Community Programs.....	---	226,921,000	---	160,143,000	---	-66,778,000
Management and Information.....	490	19,499,000	393	20,274,000	-97	+775,000
Total.....	863	433,280,000	766	306,006,000	-97	-127,274,000

* Excludes 1973 appropriation restorations of $17,842,000.

Narrative

Funds included in these activity categories support the programs and operations of the National Institute of Mental Health (NIMH). NIMH provides leadership, policies and goals for the Federal effort in the promotion of mental health and the prevention and treatment of mental illness. In carrying out these responsibilities, NIMH (1) conducts and supports research on the biological, psychological, sociological, and epidemiological aspects of mental health and mental illness; (2) supports the training of professional and paraprofessional personnel in the promotion of mental health and prevention and treatment of mental illness; (3) conducts and supports research on the development and improvement of mental health services delivery, administration and financing, and supports mental health service programs and projects; (4) collaborates with and provides technical assistance to state authorities and regional offices, and supports state and community efforts in planning, establishing, maintaining, coordinating and evaluating more effective mental health programs; (5) collaborates with, provides assistance to, and encourages other government agencies and institutions to promote mental health programs; and (6) provides information on mental health and illness to the public and to the scientific community.

A. Research: The purpose of the research program is to develop new knowledge and approaches to the causes, diagnosis, treatment, control and prevention of mental illness through basic, clinical and applied research. Funding levels are set forth in the following table:

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	373	$9,291,000	373	$9,602,000	---	+$311,000
Other expenses	---	83,617,000	---	70,587,000	---	-13,030,000
Total	373	92,908,000	373	80,189,000	---	-12,719,000
Subactivities:						
1. Research grants	---	62,219,000	---	50,430,000	---	-11,789,000
2. Hospital improvement projects	---	5,900,000	---	4,700,000	---	-1,200,000
3. Research scientist development	---	4,400,000	---	4,369,000	---	-31,000
4. Intramural Research Personnel compensation & benefits	373	20,389,000	373	20,690,000	---	+301,000
Total	373	92,908,000	373	80,189,000	---	-12,719,000

* Excludes appropriation restoration of $1,335,000.

1. Research grants: Grants are available to investigators affiliated with public or nonprofit agencies (including state, local or regional government agencies), research and academic institutions, hospitals and other organizations. Tables 1 and 2 show the distribution of research grant funds by type of grant and by program.

Table 1 - Distribution of Research Grants by Type

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations	559	$45,962,000	593	$49,356,000	+34	+$3,394,000
Competing renewals	91	6,253,000	8	774,000	-83	-5,479,000
New projects	92	7,498,000	---	---	-92	-7,498,000
Small grants	120	1,000,000	38	300,000	-82	-700,000
Supplementals	(58)	1,506,000	(--)	---	(-58)	-1,506,000
Total	862	62,219,000	639	50,430,000	-223	-11,789,000

Table 2 - Research Grants Program Distribution

Program	1975 Estimate*	1976 Estimate	Increase or Decrease
Behavioral sciences	$16,326,000	$12,043,000	-$4,283,000
Clinical research	10,476,000	8,314,000	-2,162,000
Applied research	4,707,000	2,663,000	-2,044,000
Psychopharmacology	11,700,000	9,396,000	-2,304,000
Epidemiology	1,860,000	1,490,000	-370,000
Services development	8,538,000	8,220,000	-318,000
Crime and delinquency	2,990,000	2,932,000	-58,000
Metropolitan problems	1,682,000	1,533,000	-149,000
Minority mental health	3,117,000	3,016,000	-101,000
Scientific evaluation	823,000	823,000	---
Total	62,219,000	50,430,000	-11,789,000

* Excludes 1973 appropriation restorations of $1,174,000.

Cutting across the programs set forth above are certain priority areas to which NIMH gives particular attention. Among these priorities are research efforts directed toward the mental health of children; problems of aging; schizophrenia; crime and delinquency; mental health of minorities; depression; and services research.

Continued effort will be directed to the following priority areas:

a. Child Mental Health: Today, approximately one-third of the total United States population is under 18 years of age. When one considers mental deficiency, behavior disorders, neuroses, schizophrenia, other psychoses, organic disorders, depression, personality disorders and adjustment reactions, a figure of 8 - 12 percent is considered a reasonable, sometimes conservative, estimate of the part of the under 18 population needing psychiatric services. A major research focus of child mental health research at NIMH has been in the area of childhood psychoses. Among those severe mental disorders now receiving prominent research attention are early infant autism, schizophrenia and behavioral disorders associated with hyperkinesis. With the context of the high priority placed upon research in childhood psychoses and related behaviors, NIMH plans to expand its research activities into other disorders of children such as severe intellectual retardation, speech and motor retardation, dyslexia, and anorexia nervosa. Already, a research effort in the area of childhood depressions has been recently mounted across the Institute, involving a coordinated network of inquiries into the behavioral, biochemical, and bioneurological concomitants of the illness.

b. Aging: In the 20th century the percentage of U.S. population 65 and over more than doubled from approximately 4% in 1900 to nearly 10% in 1970, while actual numbers increased from 3 million to 20 million. Approximately 5% of the aged live in institutions. Of these, approximately 12% are in mental hospitals with the remainder in nursing and other types of homes for the aged and chronically ill.

Efforts in 1976 will include (1) development of the most effective use of treatment settings and mental health facilities, including mental hospitals; community mental health centers; general hospitals; nursing homes; and primary care providers; (2) delivery of mental health services in non-traditional settings, such as retirement villages; specialized housing for the aged; homes for the aging; and senior citizen centers; (3) use of facilities based on an individual's physical, psychological, and social disability; and (4) development and testing of innovative mental health services in long-term care facilities.

c. Schizophrenia: More than two million Americans alive today will experience disruptions of their lives from this serious emotional disorder. The cost of schizophrenia in the U.S. is estimated to be $19 billion annually, two-thirds of which stems from loss of productivity.

The National Institute of Mental Health, through consultation and financial support, has joined with the World Health Organization in sponsoring a multinational study of schizophrenia. The International Pilot Study of Schizophrenia (IPSS), launched seven years ago, is a trans-cultural psychiatric investigation of 1,202 patients in nine countries. It was designed as a pilot study to lay scientific groundwork for future international epidemiological studies of schizophrenia and other psychiatric disorders.

Because of the challenge of providing for the community needs of formerly hospitalized schizophrenic patients, the Institute has given high priority to the evaluation of existing, and development of new, treatments for schizophrenia.

In the past decade there has been a burgeoning interest in the role of genetic factors in the causation of schizophrenia. Children of schizophrenics who had been adopted by normal parents were compared with normal children who lived with their natural parents. The former group still exhibited more psychiatric disorders indicating that there is a possible hereditary factor in schizophrenia.

d. Crime and delinquency: There are approximately 260,000 mentally disordered offenders handled on an average day by the U.S. corrections system. This number includes an estimated 15,000 offenders awaiting determination as to mental competency to stand trial or undergoing treatment to become competent; and 14,000 other mentally disordered offenders confined in mental hospitals (including an estimated 1,160 offenders found not guilty of crimes by reason of insanity). There are also 320,000 other persons admitted annually to State mental hospitals for behaviors which involved violation of a law but did not result in a criminal charge. A major priority area is the development, testing, and refinement of new types of community-based treatment models for delinquent and potentially delinquent children and youth who may otherwise have to be institutionalized. As part of this effort, the NIMH Center for Studies of Crime and Delinquency has developed an innovative, community based residential group home for juveniles. As of October 1974 a total of 44 homes based on the Achievement Place model were operating in 14 states.

e. Minority Mental Health: The task of the NIMH Center for Minority Group Mental Health Program is to increase the Institute's and the private sector's capabilities to meet the special mental health needs of the minority group. The Center concentrates its major energies and focuses support on mental health programs for four specific minority groups, namely: Asian Americans, American Indians, Blacks and Spanish Americans.

NIMH efforts in the area of minority mental health have included the funding of two national coalitions of mental health organizations for Spanish speaking and Asian-American population groups. The purpose of these coalitions is to serve as a communication medium, organizing local, state and regional indigenous resources. The coalitions also assess needs and develop programs for making assistance to minorities possible. Consultation and resource information are provided to local governmental units.

f. Depression: Depressive illnesses are the leading cause of all hospital admissions for psychiatric care in the United States, accounting for 25 percent of the total. The majority of persons suffering from depressive illness are not admitted to hospitals, with the result that the quarter million annually admitted as inpatients represents only a minor part of the problem. A recent survey indicates that in any given year, some 15 percent of all adults between the ages of 18 and 74 may suffer significant symptoms of depression. During FY 1976 additional and intensified efforts will be directed toward (1) prediction of therapeutic response (the use of specific biochemical markers as predictors of response to treatment); (2) studies of the potency of certain medications (the synergistic effect of two or more medications which alleviates certain types of recurrent depression); (3) studies of new psychotherapeutic approaches; and (4) exploration of the psychobiology of depressive illnesses.

g. Services Research: Research on mental health services and their delivery is central to the systematic process of monitoring emerging needs for new technical knowledge; and providing technical assistance in diffusion and utilization. Priorities of research on mental health services are: (1) children's mental health services; (2) services for the chronically and aged mentally ill; (3) planning and evaluation technology; and (4) capacity building for integration with other human services. Attention will be given to development of the most effective techniques for implementing technical assistance, including making the most appropriate match of activities to the needs of recipients.

2. Hospital Improvement Program: The program provides funds to state mental hospitals for projects which will improve the quality of patient services; encourage transition to open institutions; and develop relationships with community programs for mental health. There are no matching requirements, but grantees are required to pay a portion of the total project cost. Support to an institution may not exceed 10 years and each hospital may not receive more than $100,000 in any one year. The following table shows the distribution of hospital improvement project grants by type.

	1975 Estimate*		1976 Estimate		Increase or Decrease	
Type	No.	Amount	No..	Amount	No..	Amount
Continuations...	57	$5,700,000	47	$4,700,000	-10	-$1,000,000
New projects....	2	200,000	---	---	-2	-200,000
Total.....	59	5,900,000	47	4,700,000	-12	-1,200,000

The Hospital Improvement Program is directed toward improving the treatment, care and rehabilitation of the mentally ill in state-supported mental hospitals throughout the Nation. It is specifically focused on the use of current knowledge in demonstrating improved services for patients, stimulation of the process of change and the development of relationships with community mental health programs. Funds are available through the grant mechanism for support of programs that are designed to explore and validate new methods of treatment, and to develop new knowledge.

At the end of June 1974, a total of 280 Hospital Improvement Program grants had been awarded to 197 state mental hospitals in the country.

During FY 1974, 79 grants were funded serving an average of 75 patients per institution for a total of 5,925 patients.

A decrease of $1,200,000 in appropriations for Hospital Improvement projects is projected for 1976, representing the continued phasing-out of the program. Since this program has achieved its goal of demonstrating innovative treatment methods in every state of the union, it is felt that this area of activity can now be assumed at the state and local level.

* Excludes 1973 appropriation restoration of $161,000.

3. Research Scientist Development Program: The purpose of this program has been to support the expansion of research programs concentrated on problems of mental health, and the establishment of new mental health programs by awards to appropriate institutions for the support of individual research scientists. NIMH has focused upon the development of research capacity in the psychiatric profession; engagement of investigators from a variety of the behavioral and biomedical sciences in mental health research; and the fostering of interdisciplinary research on mental health problems. Two types of awards available under this program include research scientist development awards (to develop research potential and provide independent research experience) and research scientist awards for the support of scientists qualified to conduct independent research and thus contribute significantly to the research programs of their sponsoring institutions. Estimates for 1975 and 1976 are set forth in the following table:

Type	1975 Estimate		1976 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations.....	88	$2,708,000	130	$4,369,000	+42	+$1,661,000
Competing renewals...	6	182,000	---	---	-6	-182,000
New projects.....	38	1,397,000	---	---	-38	-1,397,000
Supplementals.....	(3)	113,000	(---)	---	(-3)	-113,000
Total.....	132	4,400,000	130	4,369,000	-2	-31,000

4. Intramural research: The Intramural Research Program conducts research into the causes, treatment, and prevention of the mental illnesses. Among these, schizophrenia and severe depression constitute the greatest problems, and are largely responsible for the fact that there are more patients in hospitals receiving treatment for mental disorders than for any other illness. Even so, measurable advances are being made, as evidenced by a steady decline in the inpatient population of public psychiatric hospitals. Following are a few examples of the recent contributions of intramural scientists to this phenomenon.

Psychiatrists are dependent upon patients' verbal reports of their reactions to various stimuli for making diagnoses and prescribing treatment. Variations in these reports make their reliability questionable. Electrophysiological techniques are being developed which demand little active participation from the subject. These reduce the number of false clues and provide the clinician with a valuable diagnostic tool not heretofore available. They are also proving useful in predicting individual differences in pharmacologic response to psychoactive drugs, a common dilemma for the physician treating depressed patients. They were used too, with considerable success, in a study of hyperactive children to differentiate those who would respond favorably to amphetamine treatment from those who would not or those who would deteriorate clinically with its use.

In another study, investigators, having confirmed earlier findings of large differences between manic-depressive and depressed patients on a variety of psychological tests (e.g. MMPI subscales, Rorschach), have run pharmacological tests on these same patients and found they differ in their responses to D- versus L-amphetamine. These differences are now being examined to determine whether amphetamine responses are predictive of the efficacy of tricyclic compounds (a class of drugs commonly used for their antidepressent effects) in these two classes of depressed patients. If they are, it will be a boon to both patients and clinicians who now must rely on clinical trial to find an effective medication for the depressed or suicidal patient.

Other pharmacologic studies center on dopamine and catecholamines, the neurotransmitters which, in theory, are most likely involved in schizophrenia and depression. Such studies in the past have been, of necessity, limited to animals; but technologically, a major step forward has been made by the development of the new methods which use, as tracers, stable (non-radioactive) isotopes. These methods substantially extend the possibilities for safe studies in human subjects and thus increase the promise of future research on biochemical factors in disease states.

With the winding down of a longitudinal study of early family development, some existing resources are being diverted to mount research projects on hyperactivity in children and of developmental processes in children. The former will be concerned primarily with genetic and biological factors while the latter will center on psychological and social factors in child development.

B. Training: The purpose of this activity is to increase the number and improve the quality of people working in the areas of mental health and mental illness by training personnel for clinical service and teaching; to develop and evaluate models of innovative training for new types of mental health personnel; and to provide continuing education for existing mental health manpower.

In addition to regular training grants, this activity supports hospital staff development grants. The hospital staff development program is designed to increase the effectiveness of staff in mental hospitals, and to translate new knowledge into more effective service to patients. This activity also includes support for mental health fellowships. Funding levels are set forth in the following tables:

Table 1 - Summary Table

	1975 Estimate*	1976 Estimate	Increase or Decrease
1. Training grants.....	$86,382,000	$36,888,000	-$49,494,000
a. Research training..	(13,062,000)	(8,647,000)	(-4,415,000)
b. Clinical training..	(73,320,000)	(28,241,000)	(-45,079,000)
2. Hospital staff development program.....	2,400,000	2,025,000	-375,000
3. Fellowships.....	5,170,000	6,487,000	+1,317,000
Total.....	93,952,000	45,400,000	-48,552,000

Table 2- Training Grants Program Distribution

	1975 Estimate**	1976 Estimate	Increase or Decrease
Research Training:			
Psychiatry.....	$500,000	---	-$500,000
Nursing.....	100,000	---	-100,000
Social Work.....	100,000	---	-100,000
Behavioral Science...	11,949,000	8,406,000	-3,543,000
Epidemiology.....	413,000	241,000	-172,000
Subtotal.....	13,062,000	8,647,000	-4,415,000
Clinical training:			
Psychiatry.....	26,140,000	11,608,000	-14,532,000
Nursing.....	8,756,000	3,639,000	-5,117,000
Social Work.....	11,784,000	4,989,000	-6,795,000
Psychology.....	10,433,000	4,842,000	-5,591,000
Continuing Education.	2,858,000	---	-2,858,000
Experimental & Spec..	13,349,000	3,163,000	-10,186,000
Subtotal.....	73,320,000	28,241,000	-45,079,000
Total.....	86,382,000	36,888,000	-49,494,000

* Excludes 1973 appropriation restorations of $3,137,000.
** Excludes 1973 appropriation restorations of $1,208,000.

Table 3 - Training Grants and Fellowships by Type

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Training Grants:						
National Research Service Award Act, Section 472, Research Training:						
Institutional Awards:						
Continuations.....	163	$11,468,000	175	$8,647,000	+12	-$2,821,000
New projects.....	28	1,594,000	---	---	-28	-1,594,000
Subtotal.....	191	13,062,000	175	8,647,000	-16	-4,415,000
Public Health Service Act Section 303: Clinical Training:						
Regular grants:						
Continuations.....	661	44,049,000	528	28,241,000	-133	-15,808,000
Competing renewals.	639	22,745,000	---	---	-639	-22,745,000
New projects.....	96	6,322,000	---	---	-96	-6,322,000
Supplementals.....	(5)	204,000	---	---	(-5)	-204,000
Subtotal.....	1,396	73,320,000	528	28,241,000	-868	-45,079,000
Hospital Staff Development grants:						
Continuations.....	35	875,000	81	2,025,000	+46	+1,150.000
New projects.....	61	1,525,000	---	---	-61	-1,525,000
Subtotal.....	96	2,400,000	81	2,025,000	-15	-375,000
Total clinical trg...	1,492	75,720,000	609	30,266,000	-883	-45,454,000
Total training grants.	1,683	88,782,000	784	38,913,000	-899	-49,869,000

* Excludes 1973 appropriation restorations of $1,208,000.

Table 3 - Training Grants and Fellowships by Type (Cont'd)

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Fellowships: National Research Service Award Act, Section 472: Research Training:						
Predoctoral:						
Continuations.....	7	$50,000	635	$4,620,000	+628	+$4,570,000
New projects.....	367	2,620,000	---	---	-367	-2,620,000
Subtotal.....	374	2,670,000	635	4,620,000	+261	+1,950,000
Postdoctoral:						
Continuations.....	16	250,000	121	1,867,000	+105	+1,617,000
New projects.....	134	2,250,000	---	---	-134	-2,250,000
Subtotal.....	150	2,500,000	121	1,867,000	-29	-633,000
Total Fellowships...	524	5,170,000	756	6,487,000	+232	+1,317,000
Total training.....	xxx	93,952,000	xxx	45,400,000	xxx	-48,552,000

* Excludes 1973 appropriation restorations of $3,137,000.

1. Training Grants: Funds are used to defray institutional costs of the training program (personnel, supplies, travel, equipment, etc.) and provide training stipends and other allowances for individuals enrolled in training programs.

On July 12, 1974 the National Research Act (Public Law 93-348) was enacted into law. Title 1 of the Act, the National Research Service Award Act, eliminated the Institute's "old" research training authority under the Public Health Service Act, replacing it with a new section (472). The new authority requires numerous changes, most significant of which is a pay-back provision. A substantial part of the existing NIMH training grants program is affected by the new authority, and FY 1975 funds for research training and fellowships (originally requested under Section 303) will be transferred to the Section 472 authority. All remaining funds (requested for purposes which P.L. 93-348 defines as "clinical training") will continue to be authorized under the revised Section 303 of the PHS Act.

The budget request reflects the continued general phase-out of training grant programs. Since its beginning in 1947 one of the missions of NIMH has been the development of well trained personnel to work in the mental health field. In the early years, the focus of support was primarily on the four core mental health professional disciplines: psychiatry, psychology, social work, and psychiatric nursing, where there was a shortage not only of manpower but also of training institutions and departments capable of educating a large number of people in these fields. Through the mechanism of the training grant, institutions received funds, initially to help them grow and later to maintain the capability they had achieved.

While these efforts did result in increased numbers of personnel in the professional disciplines, it also became clear that the need for services was growing at an even faster rate than the supply of professionals. Accordingly, programs were instituted to support the training of individuals to do research in the biological, clinical, and social aspects of mental illness, in order to arrive at a better understanding of its causes, and to provide more effective means of prevention, treatment, and care. Financial aid was also given to programs of continuing education for people working in the mental health field at all levels, and for the training of new types of mental health personnel -- both professional and non-professional.

It is now felt that mental health training programs have been developed to the point that special Federal subsidies are no longer required - particularly in those professional fields for which there is a relatively high earning potential. Accordingly, all training grant activities of NIMH (including support both for student stipends and teaching costs) will be gradually phased out. No new awards are being projected for any training grants during FY 1976. Continuations will be funded at a reduced rate.

2. Hospital Staff Development: As is the case with training grants, the 1976 budget reflects the continued phase-out of this program.

3. Fellowships: New awards in 1975 will be in the predoctoral and post-doctoral area, and will be made under the National Research Service Award Act (Section 472). Awards will support researchers in areas in which there is a demonstrated need for research manpower. The 1976 budget provides for funds to continue commitments made in 1975 and prior years.

C. General Mental Health Community Programs: Funds authorized under this activity are provided for the purpose of improving the organization, allocation, and delivery of mental health services. The program levels for 1975 and 1976 are set forth in the following table:

	1975 Estimate*		1976 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Community Mental Health Centers:						
Construction (new)..	148	$28,024,000	---	---	-148	-$28,024,000
Staffing (Continuations).....	527	172,053,000	461	$135,363,000	-66	-36,690,000
Child Mental Health (Continuations)....	161	26,844,000	161	24,780,000	---	-2,064,000
Total Community Prog..	836	226,921,000	622	160,143,000	-214	-66,778,000

The FY 1975 appropriation provides continuation support for projects funded prior to June 30, 1974. The old authorizing legislation has expired and no new legislative authorities have been enacted as of this date. Accordingly, the FY 1976 budget reflects the continued phasing out of the centers program. Workload and output data are set forth in the following table:

Analysis of Workload and Output

	1974	1975	1976	Increase or Decrease
Centers Funded.....	591	626	626	---
Centers operational....	443	520	543	+23
Patients treated:				
Children.....	407,000	471,000	535,000	+64,000
Adults.....	867,000	1,011,000	1,163,000	+152,000
Total treated.....	1,274,000	1,482,000	1,698,000	+216,000
Population Covered (millions)				
Funded Centers.....	86M	93M	93M	---
Operational Centers...	64M	77M	87M	+10M

Of the total number of Center grantees, 16% are in cities of 500,000 or more; 48% are in cities of 25,000 to 500,000; and 36% are located in cities of less than 25,000. Sixteen percent of grantees are general hospitals; 29% are mental health centers and special purpose corporations; 3% are mental hospitals; 1% are mental health clinics; and 51 percent are mixed - but principally local Government units and charitable institutions.

* Excludes 1973 appropriation restorations of $13,370,000.

D. Management and Information: This activity supports the staff who are responsible for the planning, development and administration of the grant, contract and direct operations programs relating to the area of general mental health. Funding levels are set forth in the following table:

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation & Benefits...	490	$12,943,000	393	$12,786,000	-97	-$157,000
Other Expenses.....	---	6,556,000	---	7,488,000	---	+932,000
Total.....	490	19,499,000	393	20,274,000	-97	+775,000

The net increase of $775,000 for this activity reflects the following proposed changes:

Increases:		
1. Within-grade increases.....	$239,000	
2. One extra day of pay.....	41,000	
3. Increased payments to DHEW Working Capital Fund.....	486,000	
4. Higher postage rates.....	290,000	
5. Payments to Office of Federal Employees' Compensation.....	4,000	
6. Payments to Service & Supply Fund, Office of the Assistant Secretary for Health....	101,000	
7. Federal Telecommunications System charges.	55,000	
8. Annualization of Civil Service pay increase	200,000	
Total increases.....		+$1,416,000
Decreases:		
1. Employment reductions.....		-641,000
Net change.....		+775,000

The Management and Information activity includes the resources to support the provision of leadership, direction and policy in the development of NIMH goals, policies and programs. These resources also support the development of a data base upon which program activities can be monitored and evaluated. During 1976:

... In the training area, the Institute will work with approximately 1,600 grantees, providing technical assistance and consultation in the development of alternative funding sources as Federal support is phased out. Workload in the fellowships area will remain relatively constant.

... Workload relating to the review and administration of research grants is expected to include the award of approximately 640 projects. Approximately 4 applications are received and reviewed by Institute staff for each competing award made.

... Technical assistance requirements relating to the Institute's service programs are expected to remain relatively constant in 1976.

... In the area of scientific and technical information, the Institute answers approximately 96,000 inquiries; adds 46,000 abstracts to its files; and reviews approximately 1,800 publications for relevant mental health content each year. No change in workload is anticipated for 1976.

During the current year, the Institute has substantially increased its technical assistance efforts in the following areas:

... Rape: During 1973, there was an estimated total of 51,000 forcible rapes. In 1973, 47 out of every 100,000 females were reported rape victims. Since 1968, the forcible rape rate has increased 55%. In major cities the risk of becoming a rape victim has increased to 100 per 100,000 females. Law enforcement administrators recognize that this offense is one of the most under-reported crimes. Victimization studies conducted in eight large American cities indicate that only about half of rapes are reported to the police. Several studies currently being supported and coordinated by the NIMH Center for Studies of Crime and Delinquency are investigating the social and psychological effect and impact of rape on victims. Program development activities of the Center include stimulating more research projects including those which focus on policy implications of recent changes in rape laws, and the variety of community responses to needs of rape victims. Not enough is known regarding the phenomenon of rape, especially within the framework of needs and services to women in our society; the variation of rape from other crimes of violence and deviant behavior and the short and long term effects of the criminal act on rape victims and society at large.

... Disaster Assistance: Public Law 93-288 (The Disaster Relief Act of 1974) was enacted May 22, 1974 to address itself to the area of disaster work. Title IV, Section 413, of that act authorizes the President, through the National Institute of Mental Health to provide professional counselling services, including financial assistance to State or local agencies or private mental health organizations to provide services or training of disaster workers in order to relieve mental health problems caused or aggravated by such major disasters of its aftermath. The NIMH has worked collaboratively with the Federal Disaster Assistance Administration, within the Department of Housing and Urban Development.

On October 30, 1974, the NIMH established a section on Disaster Assistance and Mental Health within its Division of Special Mental Health Programs. Staffing and guidelines for its operation are currently being augmented in concert with the mission of P.L. 93-288 and the work of the Federal Disaster Assistance Administration.

Some State groups have addressed themselves to disaster assistance by conducting workshops at the State level in crisis counselling. NIMH has maintained contact with such groups and relevant regional office staff in providing collaborative assistance. Ohio has sought funds through the State Mental Health and Retardation Authority to obtain support following the tornado in Xenia, in April, 1974. Most recently, NIMH provided crisis counselling assistance to residents of areas in Nome, Alaska, which suffered severe storms in the fall of 1974. Special attention was given to the Native American population in the area.

While ADAMHA/NIMH does not have its own grants program in disaster assistance and crisis intervention, some existing grants have been provided through those Divisions where the substantive content of the grants seemed applicable. In addition, some contracts have been let to provide relief in times of crisis. Various expressions of disturbed behavior are frequently noted as an accompaniment of crisis problems such as: suicidal behavior, severe depressions, violent acts, crying spells, irritability, inefficient work, family quarrels, anorexia, insomnia, nausea, headaches, gastrointestinal distress and fatigue. Any aspect of mental health related to this problem area would come under the province of the National Institute of Mental Health.

... Runaway Youth: Large numbers of youth in the United States - some estimates are as high as over 1,000,000 a year - leave their homes and the institutions to which they have been confined. The actions of these young runaways embody problems that are present in every social class, among countless families, and in all parts of the country. In recent years, some groups, particularly runaway houses and other "alternative" service programs for young people, have been working effectively with runaways and their families in providing a wide range of services and facilities.

In fiscal year 1974, NIMH awarded 32 contracts for 34 projects, totaling $1.5 million, as part of a short-term demonstration effort on behalf of runaway youth. The focus of this effort is to improve knowledge by demonstrating innovative services, as well as methods of training and community education, and to document and assess these services and methods. The primary purpose of this one-time demonstration program is to develop an improved understanding of the needs of youth who run away from home and lay the groundwork for future Department programming in this area.

II. Drug Abuse

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and Benefits.....	397	$7,172,000	395	$7,670,000	-2	+$498,000
Other Expenses....	---	212,712,000	---	214,188,000	---	+1,476,000
Total.....	397	219,884,000	395	221,858,000	-2	+1,974,000

Authorizations:

Research: Public Health Service Act, Section 301.

Training: Public Health Service Act, Sections 301 and 303, and National Research Service Award Act of 1974, Section 472.

Community Programs:

Project Grants and Contracts:

a. Public Health Service Act, Section 301.
b. Community Mental Health Centers Act, Sections 251 and 261.
c. Drug Abuse Office and Treatment Act, Section 410.
d. Narcotic Addict Rehabilitation Act, Section 607.

Formula Grants: Drug Abuse Office and Treatment Act, Section 409.

Management and Information: Public Health Service Act, Section 301.

Funding levels by activity are set forth in the following table:

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research.....	102	$34,000,000	102	$31,602,000	---	-$2,398,000
Training.....	---	13,787,000	---	3,000,000	---	-10,787,000
Comm. Programs....	---	157,000,000	---	172,962,000	---	+15,962,000
Mgmt. & Info.....	295	15,097,000	293	14,294,000	-2	-803,000
Total.....	397	219,884,000	395	221,858,000	-2	+1,974,000

Narrative

The drug abuse programs of the Alcohol, Drug Abuse, and Mental Health Administration are carried out through the Agency's National Institute on Drug Abuse (NIDA) which is responsible for the formulation and implementation of a full range of drug abuse prevention activities. In carrying out these responsibilities, NIDA (1) conducts and supports research in various aspects of drug abuse - from investigating psychosocial and epidemiological factors influencing drug abuse - to studying the basic chemistry of abused substances; (2) supports training programs designed to provide a sufficient number of qualified personnel in the field; (3) assists communities, either through direct project grant and contract support or through program consultation, in establishing treatment programs for drug abusers; and (4) collects and disseminates scientific, technical, and programmatic information on drug abuse from federal and state prevention efforts.

FY 1975 has been a pivotal year for NIDA. As an adjunct to its efforts to develop a national drug abuse treatment network, the Institute also took steps to assure that a uniform high quality level of treatment service is provided. These efforts will continue on a broader scale in FY 1976 with the Institute increasingly involved in the transfer of direct operational responsibility for treatment and training programs from the federal to the state sector. Concomitantly, the Institute will continue to develop its national coordinative role and, in doing so, emphasize completion within the states of the Integrated Drug Abuse Management Information System (IDAMIS), the start-up costs of which have already been borne by NIDA.

In community programs the budget maintains the 95,000 treatment slots funded in FY 1975 for which full utilization was realized earlier this year. While direct administrative responsibility for treatment will continue to shift to the states through large statewide service contracts and state formula grants, the Institute will be involved with the development and review of plans and recommendations on third party coverage of treatment costs. At least partial coverage of treatment under this mechanism will be a major NIDA goal over the next several years. In addition, NIDA will be assisting the states, through the National Training Center, in developing training curricula and standards for the credentialing of treatment personnel and the licensing of drug treatment facilities.

A. Research: New knowledge on the causes and effects of drug abuse is gained through support of basic, applied and clinical research activities and serves as the basis for the development of prevention and treatment programs. Funding levels are set forth below:

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research Grants and Contracts....	---	$31,381,000	---	$28,998,000	---	-$2,383,000
Intramural Research						
Personnel Compensation and Benefits.....	102	1,727,000	102	1,730,000	---	+3,000
Other Objects.....	---	892,000	---	874,000	---	-18,000
Total.....	102	34,000,000	102	31,602,000	---	-2,398,000

1. Grants and Contracts: Research activities focus on the development and clinical assessment of the safety and efficacy of new pharmacological therapies, including narcotic antagonists and long acting therapeutic drugs and their integration into operational treatment programs; elucidation of socio-cultural, interpersonal personality and physiological variables related to addiction risk and addictive illness; testing the abuse potential of new drugs; understanding the mechanism of action of drugs of abuse and the addiction process; and continuing research into the adverse effects of abused substances, with particular emphasis on heroin and the long term effects of marihuana use.

Research grants are awarded to public or non-profit agencies, research and academic institutions and similar organizations. Contracts are awarded on a competitive basis for directed research when there is insufficient interest in the scientific community to generate acceptable grant applications. The following tables show the distribution of research grants and contract resources by type and by program:

Research by Type Award

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants:						
Noncompeting.....	165	$14,656,000	204	$18,181,000	+39	+$3,525,000
Competing.....	10	1,140,000	13	1,466,000	+3	+326,000
New.....	58	6,185,000	9	1,054,000	-49	-5,131,000
Supplemental.....	(5)	79,000	(5)	79,000	---	---
Subtotal.....	233	22,060,000	226	20,780,000	-7	-1,280,000
RCDA (noncompeting)	3	91,000	3	91,000	---	---
Contracts:						
Noncompeting.....	68	7,266,000	71	7,600,000	+3	+334,000
Competing.....	13	1,964,000	3	527,000	-10	-1,437,000
Subtotal.....	81	9,230,000	74	8,127,000	-7	-1,103,000
Total Grants and Contracts.....	317	31,381,000	303	28,998,000	-14	-2,383,000

Research by Program

	1975 Estimate	1976 Estimate	Increase/ Decrease
Treatment Methods..	$9,866,000	$9,193,000	-$673,000
Psycho-Soc. Var....	3,908,000	3,286,000	-622,000
Epidemiology.....	3,183,000	2,967,000	-216,000
Neurophysiological	3,663,000	3,120,000	-543,000
Adverse Effects....	3,888,000	4,221,000	+333,000
Chem. & Metabolism	3,035,000	2,499,000	-536,000
Clin/Biomed. Ctr...	2,702,000	2,565,000	-137,000
Other.....	1,136,000	1,147,000	+11,000
Total Grants and Contracts.....	31,381,000	28,998,000	-2,383,000

Priority will be given to improving treatment methods, increasing knowledge concerning the adverse effects of drug use, and studying the epidemiology of drug use. In 1976, 25 new and competing awards will be made. The major research program areas are described below:

a. Development of Improved Therapeutic Knowledge for Treatment: Existing chemotherapies are being improved by the development of l-alpha-acetyl-methodol (LAAM) and Darvon-N for use in maintenance therapy. Their

long duration of action gives promise of substitution for some uses of methadone and, consequently, reduction in its diversion to unintended uses and in the number of overdose deaths. Studies on naltrexone, an experimental therapeutic drug which blocks heroin effects, are continuing in several clinics across the country. Acupuncture is being tested to determine its efficacy, if any, in detoxifying addicts. Investigations on behavioral procedures, based upon research in operant conditioning, psychopharmacology, and psychophysiology, also provide knowledge which has been translated directly into treatment procedures for opiate addiction.

b. Study of Socio-Cultural Family and Personality Variables: Socio-cultural family and personality variables are studied to determine those which may contribute to prevention or encouraging drug use in groups known to have above average risk of serious drug abuse involvement.

c. Epidemiology: Extensive data on the incidence and prevalence of drug abuse has begun to clarify usage patterns and trends in different age groups and in a variety of special populations. In FY 1976 a major new initiative will be undertaken which will use nationwide data in predicting drug abuse outbreaks in individual states, while other studies will track drug abuse experience in the United States over time in order to detect changes in incidence at the earliest possible date.

d. Neurophysiological Mechanisms: Several investigators have made significant progress in establishing the complete chain of causality between the combination of a drug with its specific receptor and the resulting pharmacological effects in the organism. In the case of opiate narcotics, this research seeks a better understanding of the mechanism responsible for the development of tolerance and dependence on these drugs and will lead to improved methods of drug abuse prevention, early intervention and treatment.

e. Adverse Effects of Drug Use: Increased emphasis is being placed on programs of preclinical toxicological evaluation of therapeutic drugs and drug delivery systems in order to determine their possible adverse side effects. Research continues to assess the adverse effects of drugs such as marihuana and cocaine, and the deleterious effects of polydrug interactions. Research on long term use of marihuana is focusing on recent reports of hazardous effects of marihuana on DNA (a most important carrier of genetic information in cells) as well as the possible behavioral and psychiatric effects of chronic use of this drug. Of high priority will be the evaluation of hazards of marihuana use on very young adolescents during the post-puberty period of maximal psychological and biological change.

f. Analysis of Chemistry and Metabolism: The development of improved methodologies for detecting drugs of abuse in body fluid and tissues continues to be an important area of study. The development of automated methodology for routine analysis, as well as the development of highly sensitive quantitative methods for research use, will provide more reliable information on the extent and nature of drug abuse.

g. Clinical/Biomedical Centers: Centers of research excellence are supported where the efforts of the basic and clinical researcher are

integrated. In this way, the period required for the clinical application of basic research findings can be shortened. Research on the narcotic receptor in one of these eight centers already shows promise of improving present methods of prevention and therapeutic intervention.

2. Direct Operations: This activity supports the operation of the Addiction Research Center (ARC) in Lexington, Kentucky. Research activities at the Center are directed primarily at the nature of the addictive process and assessing the abuse potentiality of narcotic depressants, stimulants, and hallucinogens in an attempt to identify addicting drugs early and, through appropriate control, limit their abuse. ARC operations include identification of narcotic antagonists that may have potential usefulness in the treatment of heroin addicts; validity of chemical methods for detecting drug use and dependence; and the behavioral and biological basis of addiction. The FY 1976 funding level is $2,604,000.

B. Training: The drug abuse training program seeks to ensure the availability of qualified manpower in treatment programs. As a major share of this responsibility is transferred to the states, through the combined efforts of the Regional Training Centers and technical assistance by NIDA personnel, the Institute will concentrate upon augmenting the national training effort through such activities as designing training models for sparsely populated states, and developing criteria for assessment of work experience in terms of academic credit required for credential recognition. A total of 20,587 people received training in FY 1975 and 3,072 are expected to receive training in FY 1976. This reduction reflects the shifting of responsibility to the states. Funding levels by type and program are set forth in the following table:

Training by Type Award and Program

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
NRSA Act - Sec. 472:						
Research Training:						
Fellowships:						
Predoctoral:						
Noncompeting....	---	$ ---	5	$20,000	+5	+$20,000
New.....	5	20,000	---	---	-5	-20,000
Subtotal.....	5	20,000	5	20,000	---	---
Postdoctoral:						
Noncompeting....	11	148,000	13	177,000	+2	+29,000
New.....	8	110,000	---	---	-8	-110,000
Subtotal.....	19	258,000	13	177,000	-6	-81,000
Total Fellowships	24	278,000	18	197,000	-6	-81,000

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
PHS Act - Sec. 301/303:						
Clinical Training:						
Grants (Sec. 303):						
Noncompeting.....	41	3,736,000	20	803,000	-21	-2,933,000
Competing.....	6	576,000	---	---	-6	-576,000
New.....	30	3,043,000	---	---	-30	-3,043,000
Supplemental.....	(3)	69,000	---	---	---	-69,000
Subtotal.....	77	7,424,000	20	803,000	-57	-6,621,000
Contracts (Sec. 301):						
Renewal.....	5	6,085,000	1	2,000,000	-4	-4,085,000
New.....	---	---	---	---	---	---
Subtotal.....	5	6,085,000	1	2,000,000	-4	-4,085,000
Total Clinical Training.....	82	13,509,000	21	2,803,000	-61	-10,706,000

1. Grants: Training grants are awarded to non-profit institutions for specialized training programs in the prevention and treatment of narcotic addiction and drug abuse. The training that medical students and students in health related areas receive on drug abuse is improved by increasing the number and knowledge of academic faculty and developing regular courses of instruction. Other programs support training of persons who come into direct contract with drug abusers, and provide in-service or short term instruction on treatment, rehabilitation, prevention, and evaluation of training methods. Training topics include pharmacology, urine surveillance, medical problems and patient care, treatment modalities and their management, and individual and group techniques for working with the addict. In FY 1976 support will be limited to continuation funding of training grant projects at a reduced level. No new awards will be made.

2. Research Fellowships: Under the provisions of the National Research Service Award Act of 1974 five predoctoral and thirteen postdoctoral continuation awards will be made to individuals in FY 1976. No new awards will be made in 1976.

3. Contracts: It is proposed to fund the contract for the National Drug Abuse Training Center (NDATC) in Washington, D.C. under Section 301 of the Public Health Service Act. This Center serves as a model for developing, validating, and testing training techniques and methodologies which have application for training workers in community drug abuse treatment, rehabilitation, and prevention programs. The primary effort of the NDATC in FY 1976 will be to support states in the development of their training capability by assisting with credentialing procedures, standards evaluation, training of trainers, and implementation of their statewide training systems. Estimated funding level for this contract in FY 1976 is $2,000,000. Funds are not provided for continuation of the Regional Training Centers since it is anticipated that state programs will be sufficiently developed to preclude the necessity

of continued support for regional centers.

C. Drug Abuse Community Programs: Funding levels are set forth below. The increase of $15,962,000 in FY 1976 is related primarily to continuation costs associated with 30 treatment service projects which did not require funding support in FY 1975. Therefore, this increase is not associated with a program increase.

	1975 Estimate	1976 Estimate	Increase/ Decrease
Project Grants and Contracts.....	$122,000,000	$137,962,000	+$15,962,000
Formula Grants.....	35,000,000	35,000,000	---
Total.....	157,000,000	172,962,000	+15,962,000

Community program activities center on the development and maintenance of treatment programs for drug abusers. Available data reveal that heroin addiction remains a national problem, with evidence of its use increasing in some areas of the country. At the same time, patient enrollment in NIDA funded treatment programs has grown from 55,629 in December 1973 to maximum capacity under current funding levels, of 95,000 as of March 1975.

The abuse of non-opiates, barbiturates, amphetamines, hallucinogens, cocaine, and alcohol remains a serious problem. The source of these drugs is not confined to illicit traffic, and extent of use is difficult to estimate. There are indications that approximately 2 million non-opiate abusers require clinical care.

In FY 1976 priority attention will be directed toward preparing state and local agencies to become the primary focus of future direct treatment activities. The three major long-range goals of the Institute will continue to be: (1) maintenance of the current level of federally funded project awards for services pending the development of alternative sources of support; (2) development of national treatment standards for controlling both quality and efficacy of treatment; and (3) increasing technical assistance to the states to help them assume an increase in treatment responsibilities as rapidly as possible.

The FY 1976 budget request for community programs is adequate to support the existing level of NIDA funded treatment capacity by reducing the average federal match from 73% in FY 1975 to 65% in FY 1976. Expressed in terms of static capacity, i.e., the number of patients that can be treated at any one time, the Institute will be providing full or partial support for approximately 95,000 treatment slots. Although the length of a treatment regimen can vary considerably from individual to individual and program to program, it is estimated that about 161,500 patients will again receive treatment in federally supported projects in FY 1976. Therefore, the Institute will continue to play a major role in meeting the drug abuse demands of the nation. Some shifting of funded treatment capacity among communities is planned so

that resources which are not being adequately utilized in one area can be shifted to another area that has an unmet need. The following table sets forth funding levels by type and program:

Project Grants and Contracts

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants:						
CMHC Act (261):						
Staffing						
Continuation....	24	$11,001,000	24	$10,236,000	---	-$765,000
DAOT Act (410):						
Service						
New.....	---	---	---	---	---	---
Competing.....	---	---	65	21,504,000	+65	+21,504,000
Continuation....	157	55,265,000	120	49,601,000	-37	-5,664,000
Subtotal.....	157	55,265,000	185	71,105,000	+28	+15,840,000
Demonstration						
New.....	9	3,259,000	---	---	-9	-3,259,000
Supplemental....	(1)	100,000	---	---	(-1)	-100,000
Continuation....	20	9,523,000	24	11,809,000	+4	+2,286,000
Subtotal.....	29	12,882,000	24	11,809,000	-5	-1,073,000
Prevention/Education						
New.....	---	---	---	---	---	---
Supplemental....	(2)	156,000	---	---	(-2)	-156,000
Continuation....	23	2,544,000	16	2,805,000	-7	+261,000
Subtotal.....	23	2,700,000	16	2,805,000	-7	+105,000
Total Sec. 410 Grants.....	209	70,847,000	225	85,719,000	+16	+14,872,000
Total Grants.....	233	81,848,000	249	95,955,000	+16	+14,107,000
Contracts:						
DAOT Act (410):						
Statewide						
New.....	---	---	---	---	---	---
Continuation....	27	34,018,000	26	39,630,000	-1	+5,612,000
Subtotal.....	27	34,018,000	26	39,630,000	-1	+5,612,000
IDARP						
Continuation....	35	2,000,000	---	---	-35	-2,000,000
Tech. Assistance						
New.....	1	743,000	---	---	-1	-743,000
Continuation....	2	957,000	1	777,000	-1	-180,000
Subtotal.....	3	1,700,000	1	777,000	-2	-923,000

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Evaluation						
New.....	---	---	---	---	---	---
Continuation.....	5	500,000	---	---	-5	-500,000
Subtotal.....	5	500,000	---	---	-5	-500,000
Total Sec. 410 Contracts.....	70	38,218,000	27	40,407,000	-43	+2,189,000
NARA Act (607):						
NARA Contracts						
Continuation.....	28	1,334,000	25	1,000,000	-3	-334,000
PHS Act (301):						
Psychiatric Care						
Continuation.....	1	600,000	1	600,000	---	---
Total Contracts...	99	40,152,000	53	42,007,000	-46	+1,855,000
Total Project Grants and Contracts						
New.....	10	4,258,000	---	---	-10	-4,258,000
Competing.....	---	---	65	21,504,000	+65	+21,504,000
Continuation.....	322	117,742,000	237	116,458,000	-85	-1,284,000
Total.....	332	122,000,000	302	137,962,000	-30	+15,962,000

1. Project Grants: Included under the grant mechanism of funding are:

a. Staffing Grants: These projects provide a portion of the salary costs of professional and technical personnel to staff comprehensive community centers for the treatment of narcotic addiction and drug abuse. Continuation funding will be provided for 24 projects.

b. Service Grants: These projects provide federal support for programs of treatment and rehabilitation which include detoxification services, institutional services, or community-based aftercare services. Ninety-nine of these programs, originally funded under Section 256 of the Community Mental Health Centers Act, are eligible for eight years support and will receive continuation funding in 1976. Eighty-six projects, initially funded since April 1973 under Section 410 of the Drug Abuse Office and Treatment Act will receive funding consideration in FY 1976. These projects are eligible for three years of federal support with possible renewal for an additional three years. In FY 1976 sixty-five of the 86 projects will be finishing the three years of their initial grant and will be considered for renewal. The budget includes $21,504,000 to either support these 65 projects or selectively shift funding support to other areas of the nation with a large unmet need.

c. Demonstration Grants: These projects demonstrate new or relatively effective or efficient methods for delivering health services. In FY 1976, twenty-four projects will receive continuation support. No new projects will be initiated. Included in this category is the Drug Abuse Early Warning Network which provides data on a national basis regarding the current trends and extent of drug abuse.

d. Prevention Grants: These projects provide support for prevention, education, and other special programs in the Institute's efforts to interrupt potential drug abuse instances. Continuation funding is provided for 16 projects.

Two important factors in NIDA's long-range plan to limit the Institute's direct involvement in treatment service projects will receive emphasis in FY 1976. Most importantly will be an effort to relate funding for drug treatment to available third party payments. Baseline data which is currently being collected will result in specific programs, guidelines, and technical assistance to the states directly related to this issue. Secondarily will be NIDA's continued support of demonstration projects designed to test innovative treatment techniques for potential replication at the operational level. Special emphasis will be given to the development of innovative approaches for the treatment of populations with special treatment needs, the development of innovative ways to get drug abusers into the economic mainstream, and evaluation of existing procedures and techniques in the treatment of the drug abuser.

Prevention projects are an important means of obtaining valuable information about effective methods, programs, and practices that have broad implications for a variety of primary prevention efforts. Priorities in prevention programs include investigating effective alternatives to drug abuse among disadvantaged youth and other high risk populations, and establishing family education and involvement in prevention efforts.

2. Contracts:

a. The Statewide Service Program: This is a cost reimbursement, cost-sharing contractual mechanism with the Single State Agencies under which many local drug treatment and rehabilitation programs are subcontracted. The state drug authority has primary responsibility for administration and coordination of these projects. It is anticipated that about 26 states will be supported by these contracts in FY 1976 at a total cost of $39,630,000.

b. Integrated Drug Abuse Reporting Process (IDARP): This program provides contract funds to the Single State Agencies to assist them in acquiring needed manpower, data processing services and hardware, and meeting other administrative expenses associated with the initial establishment of the Integrated Drug Abuse Management Information System (IDAMIS). IDAMIS is a nationwide information system designed to provide federal and state governments with timely and useful data on drug abuse phenomena, drug abuse treatment and prevention units, and related financial information. Funding support is not required in FY 1976.

c. Technical Assistance: These projects supplement NIDA's monitoring efforts by providing on-site assistance to programs with specific and urgent needs, especially to those programs having difficulty complying with the federal funding criteria. One technical assistance project will be refunded in FY 1976 at a total cost $777,000.

d. NARA Program: The Narcotic Addict Rehabilitation Act of 1966 (NARA) provides an opportunity for individuals addicted to narcotic drugs to volunteer for civil commitment for treatment and allows addicted individuals charged with violating certain federal criminal laws to apply for civil commitment in lieu of prosecution. A limited amount of funds will be required in FY 1976 to provide treatment services for addicts specifically requesting or expressly directed to this program.

3. Formula Grants to States: These awards are made under the authority of Section 409 of the Drug Abuse Office and Treatment Act and were first made available in FY 1973. Financial assistance is provided to the states for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions in the state and for evaluating the conduct of such functions. Funds are allocated to states based on a formula which measures the relative population, and the financial and program need of each state. Federal funding through the formula grant mechanism will be maintained at $35,000,000 in FY 1976. A recent nationwide survey has shown that the states are utilizing their formula grant funds in approximately the following manner: a) 13% for treatment and rehabilitation programs; b) 45% for prevention and education programs; c) 19% for training efforts; d) 9% for research initiatives; e) 4% for program evaluation; and f) 10% for administration. In FY 1976 formula grants will continue to serve as the mechanism through which states will assume coordinating responsibility for their drug abuse programs.

D. Management and Information: Funding levels are set forth below. The decrease for 1976 includes: $280,000 for annualization of position increases; $77,000 for annualization of the 1975 pay raise; $168,000 for built-in increases; offset by a program decrease of $1,328,000 related to a reduction in the required funding for the Integrated Drug Abuse Management Information System (IDAMIS) as well as a reduction in employment.

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and Benefits.....	295	$5,445,000	293	$5,940,000	-2	+$495,000
Other Objects.....	---	9,652,000	---	8,354,000	---	-1,298,000
Total.....	295	15,097,000	293	14,294,000	-2	-803,000

This activity supports the staff of the National Institute on Drug Abuse responsible for planning, directing, coordinating, and implementing programs of research, training, community services, and public education for prevention and control of narcotic addiction and drug abuse. Included in this activity is the National Clearinghouse for Drug Abuse Information

which distributes posters, pamphlets, publications, and other materials for use by the general public, researchers, teachers, physicians, interested groups and individuals. Also included in this effort is the Integrated Drug Abuse Management Information System (IDAMIS) which is currently in its initial design and developmental phase. When fully operational, it will provide complete data on treatment utilization, an inventory on drug abuse treatment resources, and financial information on the federal, state, and local public and private investments in drug abuse treatment. The system is designed to support information requirements of both the federal and state governments. In order to do this effectively, agreements have been reached with almost all Single State Agencies which allow the respective agencies to incorporate the federal requirements and provide the state with the capability to establish an information system that fully serves state and federal information needs. The end result of such an approach is to establish consistency and standardization of essential information across the state lines and to minimize the overall burden upon local programs.

The goal of the Institute in FY 1976 is (1) to have the information components of this system fully operational in the first part of the fiscal year; (2) to move at a rate and degree matched by individual state capabilities to fully integrate the system into the various states and, subsequently, to have the states assume the responsibility for the ongoing statewide operation of the system.

III. ALCOHOLISM

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	135	$2,997,000	130	$3,440,000	-5	$+443,000
Other expenses	---	142,790,000	---	110,759,000	---	-32,031,000
Total	135	145,787,000	130	114,199,000	-5	-31,588,000

Authorization:

Research: Public Health Service Act, Section 301;
Training: Public Health Service Act, Section 303; and the National Research Service Award Act of 1974, Section 472;
Community Programs:
Staffing: Community Mental Health Centers Act, Section 242 and 261.
Grants and Contracts: Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, Sections 304 and 311.
Formula Grants: Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, Section 301.
Management and Information: Public Health Service Act, Section 301.

Funding levels by activity are set forth in the following table:

	1975 Estimate*		1976 Estimate	
	Pos.	Amount	Pos.	Amount
Research	10	$11,009,000	26	$9,047,000
Training	---	7,540,000	---	6,958,000
Community Programs	---	116,908,000	---	91,051,000
Management & Information	125	10,330,000	104	7,143,000
Total	135	145,787,000	130	114,199,000

* Excludes $19,811,000 in 1973 appropration restorations.

NARRATIVE

The National Institute on Alcohol Abuse and Alcoholism, established by law in 1970, serves as the focal point for Federal activities in the area of alcoholism. The Institute has responsibility for formulating policies and carrying out a national program aimed at 1) accumulating and disseminating knowledge to increase the level of awareness regarding the risks and dangers associated with irresponsible drinking and, 2) building the capacity of the States and communities to establish and sustain viable programs of alcoholism prevention, treatment, and rehabilitation. In support of these broad objectives, the NIAAA administers: a program of research on the biological, psychological and social aspects of alcohol use and abuse; a program of training in alcoholism research, prevention, and treatment for a variety of persons, including professionals, paraprofessionals, and others who deal with present and potential alcohol offenders; a program of State and community support to stimulate organized service and prevention activities which meet specific local needs; and a program to disseminate a wide range of scientific and public information.

A. Research: The purpose of the alcohol research program is to acquire a better understanding of the nature of alcoholism and its causes, to improve the treatment and rehabilitation of afflicted persons, and to prevent the occurrence of alcoholic disturbances.

Included in this activity are alcohol research grants and contracts and the alcohol intramural research program. Funding levels are set forth in the following table:

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research grants and contracts.....	---	$10,522,000	---	$7,809,000	---	$-2,713,000
Intramural Research:						
Personnel compensation and benefits	10	303,000	26	624,000	+16	+321,000
Other objects.....	---	184,000	---	614,000	---	+430,000
Total.....	10	11,009,000	26	9,047,000	+16	-1,962,000

1. Grants and Contracts: Grants and contracts are available to investigators affiliated with public or private non-profit agencies (including state and local government agencies), research and academic institutions, hospitals and other organizations. The following tables show the distribution of research grants and contracts by type and by program.

Research by Type Award

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
Type	No.	Amount	No.	Amount	No.	Amount
Continuation.....	79	$5,571,000	114	$7,309,000	+35	$+1,738,000
Competing.....	34	2,384,000	---	---	-34	-2,384,000
New Projects.....	23	1,530,000	---	---	-23	-1,530,000
Supplemental.....	(5)	337,000	---	---	(-5)	-337,000
Subtotal.....	136	9,822,000	114	7,309,000	-22	-2,513,000
Contracts:						
New.....	7	700,000	---	---	-7	-700,000
Continuation.....	---	---	7	500,000	+7	+500,000
Subtotal.....	7	700,000	7	500,000	---	-200,000
Total.....	143	10,522,000	121	7,809,000	-22	-2,713,000

* Excludes $1,000 in 1973 appropriation restorations.

51-805 O - 75 -- 42

Research Grants by Program

Program	1975 Estimate*	1976 Estimate	Increase/ Decrease
Biomedical Research....	$4,616,000	$3,435,000	$-1,181,000
Psychosocial Research..	5,206,000	3,874,000	-1,332,000
Total.....	9,822,000	7,309,000	-2,513,000

Initial directions to be taken in this activity are derived from the findings and recommendations of the Research Task Force report on alcoholism research. Overall it was recommended that a balance be maintained between biomedical and psychosocial research since it is not yet possible to assign a priority hierarchy on the basis of a potential contribution which any single discipline may make to our understanding of alcoholism. In subsequent years, continuing evaluations of research progress will identify gaps in knowledge and lead to modifications in the types of research to be encouraged. Funds will be redirected as the needs of the research program change. Specific areas of attention in 1975 and 1976 are as follows:

a. Biomedical Research: Particular attention will be directed to studies on the neurology of alcoholism. Specifically, support will be given to studies aimed at understanding the effects of alcohol on electrophysiological events, on nerve cell physiology, and on neuroendocrine aspects. Continued support will be provided to such areas of past interest as liver function, blood and the circulatory system, gastrointestinal function and the metabolism of alcohol. New knowledge will be sought regarding the rapid clearance of alcohol from the body and the improvement in medical care of the alcoholic patient during withdrawal from alcohol. A total of 57 continuation awards will be made in 1976 at a reduced level.

b. Psychosocial Research: Research will be supported to identify societal influences on alcohol use, abuse and alcoholism. This includes information on subcultures, ethnic groups, social classes, and families. Some emphasis will be placed on individual psychopathology which may lead to alcohol abuse. Support will be given to research on the diagnosis and early identification of alcoholic tendencies, and on the distinguishing characteristics of the alcohol abuser. A total of 64 continuation awards will be made in 1976 at a reduced level.

2. Intramural Research: A broad-based intramural facility is an integral part of a total research program. As a part of the Institute itself, the intramural program operates with an ideal perspective of the needs for alcoholism research. Much of the success that has been experienced in other health programs can be attributed to the special advantages of an intramural setting, including the availability of a resident patient population.

An increase of 16 full time personnel will enable the laboratory to expand its studies and allow proper staffing for four program sections.

* Excludes $1,000 in 1973 appropration restorations.

a. Metabolism and Toxicology Section: Biochemical studies will be supported to investigate the causes and treatment of alcoholic "fatty liver", cirrhosis, alcoholic hypoglycemia, nutritional cirrhosis and control and effects of alcohol, acetaldehyde and acetate metabolism. Investigations will also be made into the enzymatic mechanism, kinetics, points of metabolic derangements which ultimately lead to disease, the metabolic causes of intoxication in the brain, as well as withdrawal from alcohol addiction, and hepatic coma and pre-coma.

b. Neuroscience Section: Research efforts will be supported which are aimed at understanding for the first time the basic mechanism by which ethanol induces intoxication, addiction, and withdrawal. Studies will also be funded to clarify the genetic, environmental, hormonal, nutritional, and physiological factors which affect the action of the brain following the intake of alcohol.

c. Clinical Section: Studies on alcoholic persons with chronic problems such as cirrhosis of the liver and cerebral impairment will be supported. The object of this research is to develop improved clinical methods for the treatment of illnesses related to sustained alcohol use. The section will offer comprehensive treatment, including medical and psychiatric services, for limited numbers of alcoholic persons who have abnormalities which are the subject of clinical investigation.

d. Psychology Section: New research into environmental, genetic and psychological factors associated with the use of alcohol will be initiated in close conjunction with the clinical research program.

B. Training: Alcoholism training projects are supported in order to increase the number of qualified professional and paraprofessional personnel working in the field of alcoholism, and to improve the knowledge of such persons as teachers, lawyers, law enforcement officials and others who come into contact with present and potential alcohol offenders. Training is provided for professionals working in the clinical and research areas of medicine, social work, public health, psychiatry, and psychology.

In addition to regular training grants, this activity includes support for alcoholism fellowships. Funding levels are set forth in the following table:

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Research Training:						
Institutional						
Awards.....	9	$645,000	11	$591,000	+2	$-54,000
Fellowships.....	42	331,000	40	300,000	-2	-31,000
Subtotal.....	51	976,000	51	891,000	---	-85,000
Clinical Training:						
Grants.....	90	6,564,000	119	6,067,000	+29	-497,000
Total, Training....	141	7,540,000	170	6,958,000	+29	-582,000

* Excludes $3,573,000 in 1973 appropriation restorations.

1. Grants: Funding levels by type and program are set forth in the following table:

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
NRSA Act-Sec. 472:						
Research Trng:						
Inst. Awards:						
Noncompeting..	2	$151,000	11	$591,000	+9	$+440,000
Competing.....	---	---	---	---	---	---
New.....	7	483,000	---	---	-7	-483,000
Supplemental..	(1)	11,000	---	---	(-11)	-11,000
Subtotal.....	9	645,000	11	591,000	+2	-54,000
PHS Act-Sec. 303:						
Clinical Grants:						
Noncompeting...	23	1,545,000	119	6,067,000	+96	+4,522,000
Competing.....	4	365,000	---	---	-4	-365,000
New.....	63	4,548,000	---	---	-63	-4,548,000
Supplemental...	(6)	106,000	---	---	(-6)	-106,000
Subtotal.....	90	6,564,000	119	6,067,000	+29	-497,000
Total, Training Grants.....	99	7,209,000	130	6,658,000	+31	-551,000

Funds are used to defray institutional costs of training facilities and provide training stipends to individuals enrolled in the training programs.

The Institute supports a broad variety of alcoholism training to serve the needs of manpower in the health professional ranks, and in various paraprofessional fields, as well as the needs of individuals and groups who are frequently exposed to the alcoholism problem in their regular work. This latter category includes the clergy, attorneys, teachers, police, and key individuals to whom people in trouble often turn for help.

The Institute has also established four Area Alcoholism Education and Training Programs (AAETP's), each with responsibility for its own geographic sector of the nation. The purpose of these programs is to identify the specific manpower needs of target populations, giving particular attention to high risk groups, and to supply resources in order to develop additional manpower and improve existing manpower according to these assessed needs. The 1976 Budget provides for the continuation funding of existing training grants at a reduced level. It is estimated that budget authority funding levels in FY 1975 and FY 1976 will support 17,674 and 8,353 trainees respectively.

* Excludes $3,552,000 in 1973 appropriation restorations.

2. Fellowships: Funding levels by type and program are set forth below:

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
NRSA Act-Sec. 472:						
Research Trng:						
Fellowships:						
Predoctoral:						
Noncompeting	---	---	20	$80,000	+20	$+80,000
New.....	20	$80,000	---	---	-20	-80,000
Subtotal...	20	80,000	20	80,000	---	---
Postdoctoral:						
Noncompeting	4	32,000	20	220,000	+16	+188,000
New.....	18	219,000	---	---	-18	-219,000
Subtotal.....	22	251,000	20	220,000	-2	-31,000
Total, Fellows...	42	331,000	40	300,000	-2	-31,000

C. Alcohol Community Programs: Funds authorized under this activity are provided primarily to establish alcoholism prevention, treatment, and rehabilitation programs. Funding levels and program descriptions are provided in the following material:

	1975 Estimate**	1976 Estimate	Increase/ Decrease
Project Grants and Contracts.....	$64,908,000	$45,451,000	$-19,457,000
Formula Grants.....	52,000,000	45,600,000	-6,400,000
Total.....	116,908,000	91,051,000	-25,857,000

1. Project Grants and Contracts: The following tables show the distribution of project grants and contracts by type and by program.

	1975 Estimate**		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Staffing:						
Noncompeting...	45	$11,051,000	45	$10,431,000	---	$-620,000
Subtotal, Staffing	45	11,051,000	45	10,431,000	---	-620,000
Grants:						
Noncompeting...	97	12,082,000	286	31,593,000	+189	+19,511,000
Competing.....	188	16,511,000	---	---	-188	-16,511,000
New.....	101	17,385,000	---	---	-101	-17,385,000
Supplemental...	(16)	1,187,000	---	---	(-16)	-1,187,000
Subtotal, Grants.	386	47,165,000	286	31,593,000	-100	-15,572,000
Contracts:						
Noncompeting...	5	907,000	13	3,427,000	+8	+2,520,000
New.....	20	5,785,000	---	---	-20	-5,785,000
Subtotal, Contr..	25	6,692,000	13	3,427,000	-12	-3,265,000
Total, Grants and Contracts.....	456	64,908,000	344	45,451,000	-112	-19,457,000

* Excludes $21,000 in FY 1973 appropriation restorations.
** Excludes $16,032,000 in FY 1973 appropriation restorations.

Project Grants and Contracts by Program

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Staffing Grants..	45	$11,051,000	45	$10,431,000	---	$-620,000
Grants & Contracts:						
Grants:						
Occupational...	23	1,850,000	40	2,579,000	+17	+729,000
Indians.....	121	11,135,000	37	3,326,000	-84	-7,809,000
Public Inebriate	13	5,126,000	24	4,783,000	+1	-343,000
Drinking Driver	13	2,279,000	11	951,000	-2	-1,328,000
Poverty.....	124	9,560,000	9	945,000	-115	-8,615,000
Project Demon..	65	12,501,000	102	13,415,000	+37	+914,000
Prevention.....	12	2,214,000	48	3,094,000	+36	+880,000
Uniform Act....	15	2,500,000	15	2,500,000	---	---
Subtotal, Grants	386	47,165,000	286	31,593,000	-100	-15,572,000
Project Contracts:						
Incentive.....	12	3,500,000	12	2,263,000	---	-1,237,000
Technical Asst.	1	1,800,000	1	1,164,000	---	-636,000
Other Contracts	12	1,392,000	---	---	-12	-1,392,000
Subtotal, Contr.	25	6,692,000	13	3,427,000	-12	-3,265,000
Subtotal, G & C..	411	53,857,000	299	35,020,000	-112	-18,837,000
Total.....	456	64,908,000	344	45,451,000	-112	-19,457,000

The purpose of this activity is to stimulate community efforts aimed at reducing the incidence, prevalence, and severity of alcohol abuse through programs of prevention, treatment, and rehabilitation. Emphasis is placed on supporting programs reaching Indians, and communities composed of poverty and minority group populations which have a high incidence of alcoholism and which have traditionally been lacking in services. In addition, programs are supported to meet the particular needs of employed alcoholics and drinking drivers. High priority programs receiving support in 1975 and 1976 include the following:

a. Indian Alcohol Program: Projects are supported which provide treatment and rehabilitation services to American Indian populations. The Institute feels especially committed to supporting treatment programs for American Indians, owing to the severity of the alcohol program among this population group, and to the moral and legal relationship between the Federal government and the Indian people. The Institute seeks to provide more effective services by integrating Indian cultural patterns into the services provided. This is achieved through the hiring of Indian staff for Indian programs, working through individual tribal mores, and emphasizing the Indian's image of himself. In 1976, a total of 37 projects will be awarded.

b. Poverty Program: A variety of services provided by different agencies in the communities are coordinated and made available to the low income alcoholic person and his family. Specifically, these community projects attempt to identify low income families with alcohol problems, and facilitate their entry into local service delivery outlets. In 1976, a total of 9 projects will be awarded.

* Excludes $16,032,000 in 1973 appropriation restorations.

c. Public Inebriate Program: Projects funded are designed to assist alcoholic individuals belonging to the "skid row" way of life who are often in serious need of food, clothing, and shelter as well as alcoholism treatment services. In 1976, a total of 24 projects will be awarded.

d. Project Demonstration Programs: This collective category includes projects designed to provide treatment and rehabilitation services to certain high risk populations including Women, Blacks, Spanish-Speaking Americans, and alcoholic persons encountered by the criminal justice system. In 1976, a total of 102 projects will be awarded.

e. Drinking Driver Program: This program has been implemented as a joint effort with the Department of Transportation. Funds under this program support treatment and rehabilitation projects for problem drinking drivers identified through the highway safety efforts of the Department of Transportation. In 1976, a total of 11 projects will be awarded.

f. Occupational Alcoholism Program: This program consists of projects aimed at the development of services within the industrial environment which are capable of reaching the employed problem drinker early in the course of his illness. The purpose is to establish new methods of effective case-finding, referral systems, and industry-union-community relationships to facilitate the provision of services to alcoholic employees. In FY 1976, a total of 40 projects will be awarded.

g. Prevention Program: This programs consists of two types of projects:

(1) Community Prevention projects are supported to disseminate alcohol abuse information within the community. Support is available for programs which seek to stimulate and coordinate preventive efforts within educational institutions, health care and law enforcement agencies, and civic organizations.

(2) Youth Education projects are funded to design and implement prevention programs among youth and to develop innovative instructional materials on the use and misuse of alcohol. While these projects focus primarily on youth, they also involve the adults who influence a youth's decisions. These include parents, teachers, health providers, and law enforcement officers.

In FY 1976, a total of 48 projects will be awarded.

In 1976, the budget will provide continuation funding for grants initiated in 1975 and before at a reduced level. This funding level does not provide for a fourth year of support for projects receiving their final year of committed support in FY 1975. It is estimated that Institute supported projects will serve 220,000 persons in 1975 and 120,000 in 1976.

2. Formula Grants: Formula grants provide funds to the States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of effective prevention, treatment, and rehabilitation programs. Funds are allotted according to a formula which is based upon population, financial need and the need for more effective alcohol programs. All of the States, the District of Columbia, Puerto Rico, the Trust Territory of the Pacific Islands, Guam, American Samoa, and the Virgin Islands, receive allotments.

The national priority of identification, treatment, and prevention of alcoholism is too broad for a single national approach. The formula grant program encourages the States to develop their capability to plan and execute alcohol programs which meet the particular needs of small divisions of the

national alcoholic population. Treatment services comprise approximately 67% of the total formula grant dollars. The remaining funds are directed to program development, State and local program administration, and prevention and educational programs. The budget request for 1976 is $45,600,000, a reduction of $6,400,000 below the 1975 level of $52,000,000.

D. Alcohol Management and Information: Funding levels are set forth below. The decrease for 1976 includes a program decrease of $3,651,000 of which $210,000 is related to an employment reduction of 21 positions. This decrease is offset by increases of $43,000 for annualization of 1975 pay raise; $360,000 for annualization of 1975 position increases; and $61,000 for built-in increases.

	1975 Estimate*		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..	125	$2,694,000	104	$2,816,000	-21	$+122,000
Other Objects.....	---	7,636,000	---	4,327,000	---	-3,309,000
Total.....	125	10,330,000	104	7,143,000	-21	-3,187,000

The Management and Information activity includes the resources to support the staff of the Alcohol Institute who direct the development of the Institute's goals, policies, and programs. Also included are funds to support the National Clearinghouse for Alcohol Information and the National Center for Alcohol Education.

Changing the national attitude toward those who drink, and bringing openness to a subject which has been misunderstood and stigmatized for two centuries is at the heart of the Institute's mission. The National Clearinghouse for Alcohol Information was established within the Institute in July, 1972, to serve as the national focal point for the collection and dissemination of world-wide information on alcohol abuse and alcoholism. As its basic function, the Clearinghouse continuously receives information from nationwide data sources, casts it in appropriate forms and contexts, and disseminates it in a timely manner to all sectors of the population. Available alcohol literature from around the world is scanned, selected, acquired, analyzed, and housed in an ever-expanding repository of alcohol information. The magnitude of the Clearinghouse operation is evidenced by the estimated 287,000 information items disseminated each month.

Another important arm of the Institute's prevention and education effort is the National Center for Alcohol Education. The basic purpose of this Center is the improvement of alcohol-related services through the education of policy makers and through the development of curriculum materials and model training programs which can be broadly adapted at the State and local levels. The activities of the Center have included a national survey of alcoholism education and training activities, the development and testing of more effective preventive curricula, and Executive Seminars. The seminars are held periodically during the year, and are composed of State Directors of alcoholism, policy makers, and other leaders in the alcoholism field who exchange information on innovative program and legislative developments which can be duplicated in other parts of the country.

The 1976 budget request will reduce the activities carried on by the National Clearinghouse for Alcohol Information. In addition, a number of public information and general support contracts will be discontinued. Finally, the 1976 budget provides a reduction of 21 positions and related costs totalling $210,000.

* Excludes $205,000 in 1973 appropriation restorations.

IV Buildings and Facilities

	1975 Estimate	1976 Estimate	Increase or Decrease
Personnel compensation and benefits.....	---	---	---
Other expenses, Obligations.....	($7,522,000)	---	(-$7,522,000)
Total.....	($7,522,000)	---	(-7,522,000)

Direct construction and facility improvement projects relating to facilities of the Alcohol, Drug Abuse, and Mental Health Administration are funded under this activity. Although utilized primarily for work at Saint Elizabeths Hospital, this activity is also available as the account for support of capital improvements at other ADAMHA facilities.

Air conditioning projects are currently in various stages of completion at three facilities of Saint Elizabeths Hospital. The planning phase is complete for the unit to be installed in John Howard Pavilion; installation is commencing at Dix Pavilion, the facility which houses the Area D Community Mental Health Center; and work is almost complete at Nichols Building, one of the hospital's larger general treatment facilities. It is also expected that drawings and specifications will be commenced for air conditioning of a fourth facility, the W.W. Eldridge (Medical and Surgical) Building. Renovation of the hospital's sanitary and storm sewer facilities is expected to be completed late this fiscal year. The overhaul of wiring, plumbing, and exterior screening is currently underway in several facilities.

No new appropriations are requested. It is anticipated that construction funds will be requested upon consummation of the transfer of Saint Elizabeths Hospital to the District of Columbia.

V. PROGRAM DIRECTION

	1975 Estimate		1976 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits	301	$6,748,000	299	$7,043,000	-2	$+295,000
Other expenses....	---	3,711,000	---	4,521,000	---	+810,000
Total.....	301	10,459,000	299	11,564,000	-2	+1,105,000

Narrative

This activity, authorized by Section 301 of the Public Health Service Act, includes funds for the following purposes:

	1975 Estimate		1976 Estimate	
	Pos.	Amount	Pos.	Amount
A. Staff support for the Office of the Administrator, Alcohol, Drug Abuse and Mental Health Administration.....	176	$4,929,000	174	$4,974,000
B. Staff support for Agency positions assigned to the DHEW Regional Offices	125	3,998,000	125	4,069,000
C. Rental costs for building occupied by Agency staff.....	---	1,532,000	---	2,521,000
Total.....	301	10,459,000	299	11,564,000

The Office of the Administrator, ADAMHA, includes the staff responsible for the overall direction and management of the Agency. The functions carried out in the Administrator's office include administrative management services, program planning and evaluation, program coordination, and public affairs activities.

The staff assigned to the regional offices carry out programs of assistance to the states and serve as field units providing technical assistance on agency programs to state and community institutions. Regional offices have the responsibility for the administration, on a project basis, of the community mental health centers programs, the hospital improvement and hospital staff development programs, and the alcoholism formula grant program.

The Public Building Amendment of 1972 (P.L. 93-313) requires each agency occupying space assigned by GSA to reimburse them for that space. A total of $2,521,000 is requested for this purpose in FY 1976, an increase of $989,000 over the 1974 level.

The overall increase of $1,105,000 for 1976 includes mandatory increases of $989,000 for building rental costs, $134,000 for annualization of 1975 pay raise, $144,000 for within-grade increase and $47,000 for one extra day pay. These increases are offset by a program decrease of $209,000, of which $30,000 is associated with an employment reduction of 2 positions.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Research (PHS Act, Sections 301 and 303).

1975 Estimate		1976 Estimate		
		Authorization	Budget Estimate	
Pos.	Amount		Pos.	Amount
373	$92,908,000*	Indefinite	373	$80,189,000

Purpose: Provides funds to develop new knowledge and approaches to the causes, diagnosis, treatment, control and prevention of mental illness, through basic, applied and clinical research.

Explanation: Regular research grants go to investigators affiliated with hospitals, academic and research institutions, and other non-profit organizations. There are no matching requirements, but the grantee is required to share a portion of the costs. Hospital improvement grants are specifically focused on the use of current knowledge in demonstrating improved services for patients, stimulation of the process of change, and the development of relationships with community programs for mental health. Research scientist grants support the expansion of research programs and the establishment of new initiatives, through awards to institutions for the support of individual research scientists. Intramural research efforts address the causes, treatment and prevention of mental illness at the laboratory level, with emphasis upon the studies of schizophrenia and depression.

Accomplishments in 1975: In regular research grant awards, an estimated total of 92 new; 91 renewals; 120 small grants; 58 supplementals, and 559 continuations. For hospital improvement projects, 57 continuations and 2 new awards. In the research scientist development program, 38 new awards and 6 renewals; 3 supplementals, and 88 continuations.

Objectives for 1976: Regular research grant awards will include 8 renewals; 38 small grants; and 593 continuations. Emphasis will be upon the areas of child mental health, aging, schizophrenia, crime and delinquency; minority mental health; depression and services development. A total of 47 continuation hospital improvement awards will be made, with the ultimate intention of phasing out the program. The research scientist development program will fund a total of 130 continuations.

*Excludes 1973 appropriation restoration of $1,335,000.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Training grants and fellowships (National Research Service Award Act of 1974 (Section 472) for research training; and Section 303, Public Health Service Act for clinical training).

1975 Estimate*		1976 Estimate			
		Act & Sec.	Author--zation	Budget Estimate	
Pos.	Amount			Pos.	Amount
---	$93,952,000			---	$45,400,000
---	(75,720,000)	(PHS-303-	Indefinite)	---	(30,266,000)
---	(18,232,000)	(NRSA-472-	Expired)	---	(15,134,000)**

Purpose: Training grants and fellowships support the effort to improve the quality of people working in the mental health field, and provide training for research relating to the problems of mental health.

Explanation: Research training programs (fellowships, and the behavioral sciences, along with very small portions of psychiatry, nursing and social work) fall within the new provisions of the National Research Service Award (NRSA) Act, the most significant features of which are support on the basis of national need, and a pay-back provision. Clinical training (experimental programs, continuing education and most of psychiatry, nursing, social work, and psychology) is administered under the PHS Act.

Accomplishments in 1975: Among the regular training grants, there will be a total of 124 new awards; 639 renewals; 5 supplementals, and 824 continuations. Similarly, 35 hospital staff development continuations and 61 new awards will be made. In the fellowships area, a total of 367 new predoctoral and 134 new post-doctoral awards will be made. There will be 7 predoctoral and 16 post-doctoral continuations.

Objectives for 1976: Phase-out of the training and hospital staff development programs. A total of 756 fellowship awards, all of which represent continuations.

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* Excludes 1973 appropriation restorations of $3,137,000.

** New authorizing legislation will be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Construction (Authority expired June 30, 1974)

1975 Estimate*		1976 Estimate		
		Authorization	Budget Estimate	
Pos.	Amount		Pos.	Amount
---	$14,250,000	Expired	---	$ ---
(---)	(28,024,000)		---	---

Purpose: Grants have been made for the construction of public and other non-profit community mental health centers. Construction grants assist communities in establishing appropriate facilities for the delivery of comprehensive community mental health services by supplementing state, local and private financial resources.

Explanation: Funds appropriated for this program are allocated to the states on a formula basis, taking into account such factors as population and per capita income. Grants are awarded on a matching basis with the percent of Federal support varying depending upon whether or not the catchment area served has been designated as a "poverty area".

Accomplishments in 1975: Appropriations of $14,250,000 are available under the Continuing resolution in addition to funds available from 1974.

Objectives for 1976: No new appropriations requested.

* Excludes 1973 appropriation restorations of $13,370,000.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Staffing Section 224, Community Mental Health Centers Act).

1975 Estimate		1976 Estimate		
		Authorization	Budget Estimate	
Pos.	Amount		Pos.	Amount
---	$172,053,000	Sums Necessary	---	$135,363,000

Purpose: Grants have been made to assist in the establishment and operations of community mental health centers in areas designated by state mental health authorities as "catchment areas" (geographic areas containing between 75,000 and 200,000 people among which there is to be a coordinated, comprehensive system for providing mental health care). Grants are awarded on a project basis to eligible centers for partial support of staffing costs of professional and technical personnel.

Explanation: This assistance has enabled the community to initiate new or improved mental health services and make them available while longer term sources of financial support are being developed. Grants are awarded on a matching basis with the percent of Federal support varying, depending on whether the catchment area served has been designated as a "poverty" area.

Accomplishments in 1975: Continuation support will be provided for a total of 527 projects. A total of 520 centers are expected to be operational by June 30, 1975.

Objectives for 1976: Continuation support will be provided for a total of 461 projects. A total of 543 centers are expected to be operational by June 30, 1976.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Childrens' Services (Section 271, Community Mental Health Centers Act).

1975 Estimate		1976 Estimate		
		Authorization	Budget Estimate	
Pos.	Amount		Pos.	Amount
---	$26,844,000	Sums Necessary	---	$24,780,000

Purpose: This activity supports grants which will improve the quality and quantity of services to children through specialized staffing grants.

Explanation: Funds are used to provide staffing support to existing community mental health centers or other qualified public or non-profit agencies and organizations, for the establishment or expansion of mental health services to children.

Accomplishments in 1975: Continuation support will be provided for a total of 161 projects.

Objectives for 1976: Continuation support for 161 projects.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Management and Information (Public Health Service Act, Sections 301 and 303)

1975 Estimate		1976 Estimate		
		Authorization	Budget Estimate	
Pos.	Amount		Pos.	Amount
490	$19,499,000	Indefinite	393	$20,274,000

Purpose and Explanation: This activity supports the staff who are responsible for the planning, development and administration of the grants and contract programs included in the general mental health activities. Also included are the resources required for overall direction and management of the Institute, including program planning and evaluation, biometric and legislative services, administrative management, central office coordination of regional programs, and maintenance of Institute relationship with other branches of the Administration - and with state and community organizations.

Accomplishments in 1975: Technical assistance to, and consultation with, approximately 4,100 grantees; review and administration of approximately 1,000 grant applications; response to 96,000 mental health inquiries; and review of 1,800 publications for relevant mental health content.

Objectives in 1976: Approximately the same level of effort as FY 1975.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Research - (Public Health Service Act, Section 301)

1975 Estimate		1976				
					Budget Estimate	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
102	$34,000,000	PHS	301	Indefinite	102	$31,602,000

Purpose: This subactivity supports drug abuse research grant and contract programs of NIDA and operation of the Addiction Research Center located in Lexington, Kentucky. Drug abuse research grants and contracts support the development of new knowledge and approaches to the causes, diagnosis, treatment, control and prevention of narcotic addiction and drug abuse through basic, clinical, and applied research.

Explanation: Project grants are available on a non-matching basis to public and private non-profit institutions. Contracts are awarded on the basis of competition for directed research activities. In addition, research career awards are available under this activity. Intramural research activities are supported at the Addiction Research Center, whose primary function is to test drugs for their abuse potential prior to their being made available for general use.

Accomplishments in 1975: During 1975 NIDA provided support for 317 research grants and contracts of which 236 were continuations. In addition to continuing other existing efforts, NIDA expanded clinical testing of long-acting methadone substitutes and safer, more effective, narcotic antagonists; increased research efforts on the possible physical, psychological, and genetic dangers of marihuana use; developed new methods of detecting drugs of abuse in tissues and body fluids; and expanded research into the extent of treatment hazards associated with the increasing number of patients being treated in opiate substitute programs over long periods of time.

Objectives for 1976: The FY 1976 request provides funding support for ongoing areas of major research including (1) basic studies on the mechanisms of opiates, methadone, and narcotic antagonists at selected clinics across the country; (2) the relation of new knowledge of neurophysiological functioning to improved methods of drug abuse prevention, early intervention, and treatment; (3) identification of the incidence and shifting national patterns of drug abuse activity using the Drug Abuse Warning Network, the Client Oriented Data Acquisition Process, and epidemiology studies; (4) evaluation of newer alternative treatment methods, with emphasis on Darvon-N, acupuncture, and behavior modification techniques, and (5) investigation into the potential relationship between heredity and a predisposition to drug addiction. The budget provides funding for 278 continuation projects and 25 new and competing projects.

51-805 O - 75 -- 43

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Training - (Public Health Service Act, Sections 301, 303, and National Research Service Award Act of 1974, Section 472)

1975 Estimate		1976				
					Budget Estimate	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
---	$6,085,000	DAOT	410	Expired	---	$ ---
---	7,424,000	PHS	303	Indefinite	---	803,000
---	278,000	NRSA	472	Expired 1/	---	197,000
---	---	PHS	301	Indefinite	---	2,000,000
---	13,787,000				---	3,000,000

Purpose: This activity supports training designed to increase the number and improve the quality and knowledge of people working in the area of narcotic addiction and drug abuse.

Explanation: Training grants are awarded to organizations to enable them to defray institutional costs of training programs, and to provide stipends to enrolled individuals. These are available to public or private non-profit institutions. The National Drug Abuse Training Center (NDATC) contract provides support and coordination for a national training system. Fellowships are awarded in support of research training.

Accomplishments in 1975: NIDA has begun to establish a coordinated, quality controlled national training system focused around the NDATC and the training programs developed by several states in conjunction with NIDA initiatives. This system apprises states of the resources available to them for use in meeting their training needs and assists them in developing their own programs to meet those needs. With the progress of this effort, NIDA has been able to limit its direct training involvement to the funding of three rather than six regional training centers and to continue the phasing out of the training grant program. Twenty-four research training fellowships and 77 training grants received funding.

Objectives for 1976: The National Drug Abuse Training Center will continue its role as the center of the national training system by serving as a model for developing, validating, testing, and transmitting training techniques and methodologies which have potential for application in community drug abuse treatment, rehabilitation, and prevention programs. Due to the progress in this area plus the increased state responsibility for training of treatment personnel, it will no longer be necessary for NIDA to continue to fund the regional training centers. The 1976 request provides funds for 20 grants and 18 research training fellowships having continuation requirements.

1/ Authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Community Programs - Project Grants and Contracts (Community Mental Health Centers Act, Section 261; Drug Abuse Office and Treatment Act of 1972, Section 410; Narcotic Addict Rehabilitation Act, Section 607; and Public Health Service Act, Section 301)

1975 Estimate		1976				
					Budget Estimate	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
---	$11,001,000	CMHC	261	"Sums as Nec."	---	$10,236,000
---	109,065,000	DAOT	410	Expired 1/	---	126,126,000
---	1,334,000	NARA	607	"Sums as Nec."	---	1,000,000
---	600,000	PHS	301	Indefinite	---	600,000
---	122,000,000				---	137,962,000

Purpose: This subactivity supports grants and contracts to develop and conduct comprehensive health and education programs for the prevention and treatment of drug abuse, thereby reducing the problems associated with drug use and abuse in the United States.

Explanation: Project grants and contracts include a variety of programs in support of drug abuse prevention, demonstration and treatment efforts. Most of these are drug abuse service projects which provide partial federal support to treatment and rehabilitation programs which include detoxification services, institutional services, or community-based aftercare services.

Accomplishments in 1975: A total of 332 awards were made of which 322 were continuations. Nine new demonstration grants were funded along with one new technical assistance contract. The major objective in FY 1975 was to establish full utilization of the 95,000 federally funded treatment slots. Consistent with the increase in treatment utilization at the community level, the federal patient care provided under the Narcotic Addict Rehabilitation Act was reduced in FY 1975. In addition, FY 1975 witnessed increased usage of statewide service contracts as a means of promoting direct administrative responsibility for treatment at the local level.

Objectives for 1976: In FY 1976 NIDA will continue to shift treatment service resources from project grants to statewide service contracts wherever possible. The current 95,000 federally funded treatment slots will be maintained, although with increased non-federal funding. Technical assistance to the states will continue in order to prepare them to rapidly assume an increase in prevention responsibilities. National treatment standards for controlling both quality and efficacy of treatment will be developed. Some shifting of funded treatment capacity among communities is planned to more effectively utilize resources.

1/ Authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Community Programs - Grants to States (Drug Abuse Office and Treatment Act of 1972, Section 409)

1975 Estimate		1976			Budget Estimate	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
---	$35,000,000	DAOT	409	Expired 1/	---	$35,000,000

Purpose: These grants made under the authority of Section 409 of the DAOT Act provide financial assistance to states for planning, establishing, conducting and coordinating projects for the development of more effective drug abuse prevention functions in the state and for evaluating the conduct of such functions.

Explanation: Funds are allocated to states based on the relative population, financial and program need. A portion of the allotment may be used to pay a part of the costs of administering the state drug abuse prevention programs with the remainder being used for prevention activities to include treatment, training, research, education, and evaluation.

Accomplishments in 1975: During FY 1975 formula grants began serving as a mechanism through which the states assumed an increasing responsibility for drug abuse programs. They were awarded to the states to cover multiple aspects of drug abuse, e.g., planning, treatment services, information development and reporting, and program administration. In FY 1975 the states refined their first year plans to reflect new incidence and prevalence data, additional needs, and adequate resources to meet them. An analysis of these plans indicates that only approximately 13% of these funds will be used for treatment services with the majority being used to fund other prevention activities.

Objectives for 1976: In FY 1976 the states will be encouraged to address the problem of quality care in the treatment and rehabilitation centers. Additionally, states will begin to play a greater role in developing sources of third party payments in the treatment of drug abuse. State agencies will also expand their coordination of the various drug related services within their state.

1/ Authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Management and Information - (Public Health Service Act, Section 301)

1975 Estimate		1976				
					Budget Estimate	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
295	$15,097,000	PHS	301	Indefinite	293	$14,294,000

Purpose: Funding is provided for the overall planning, direction, administration, and coordination of the National Institute on Drug Abuse's treatment, rehabilitation, research, training, education, and information programs.

Explanation: This subactivity provides support for the National Institute on Drug Abuse including personnel for planning, coordination, analysis, evaluation, and general administrative management. It supports the activities of the Integrated Drug Abuse Management Information System which is a national program responsible for the collection and dissemination of information on educational resources, government and private activities, treatment facilities, and the populations served in the drug abuse prevention and treatment field.

Accomplishments in 1975: In FY 1975 the Institute further developed its management capabilities to more effectively coordinate and direct a national program on the drug abuse prevention effort. The Institute moved significantly closer to establishing a total information system to meet the planning and management needs of the Federal and State Governments. This information system will furnish the Institute and the states with data that will promote sound resource allocation, development of new policies, implementation of national strategy, and specialized research efforts as well as serve as a source of information for the public, special groups and governmental agencies. The initial phase of this program became operational during FY 1975.

Objectives for 1976: The major effort will center upon assisting the states in assuming a more participatory and supportive position in the collection of vital information for the planning and management of the drug abuse problem. Through the continued development of these information systems at the state level, the Institute's objective of increasing the responsibility of state and local programs will be further strengthened.

In addition, personnel will increasingly work with the state sector to provide the technical assistance necessary to allow them to assume a more substantive role in the direct administration of programs. Effective use of third party payments and investigation of the implications and applicability of National Health Insurance proposals will also be a major consideration in FY 1976. In addition, an increased emphasis will be placed on program evaluation and the international aspects of drug abuse, two important areas necessarily limited in past years due to the urgent need to establish a national drug abuse treatment program. Of particular interest in the latter case is the determination of the drug abuse incidence and patterns among American civilians overseas.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, & Mental Health

Program Purpose & Accomplishments

Activity: Alcoholism - Research - (Public Health Service Act, Section 301).

1975 Estimate		1976		
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
10	$11,009,000 1/	Indefinite	26	$9,047,000

Purpose: This subactivity supports alcoholism research grants and contracts and the alcohol intramural research program located at Saint Elizabeths Hospital. The purpose of these efforts is to acquire a better understanding of the nature of alcoholism and its causes, to improve the treatment and rehabilitation of afflicted persons, and to prevent the occurrence of alcoholic disturbances.

Explanation: Project grants, including research scientist development awards, are made to public and private non-profit institutions. Contracts are made in support of more directed research activities. Intramural research studies are supported to analyze the biological, behavioral and biochemical correlates of alcoholism in animals and man, and are coordinated with the research grant and contract efforts.

Accomplishments in 1975: During 1975, the NIAAA provided support for 143 grants and contracts, including 79 continuation awards. Six of the continuation awards were for the research career program. A total of 64 new and competing renewal awards were made, of which 3 were research career awards. Competing awards were targeted to biomedical studies regarding the rapid clearance of alcohol from the body, the blocking of the intoxicating effects of alcohol, and the improvement in the medical care of the alcoholic patient during withdrawal from alcohol. Areas of expansion in psychosocial research include studies on the diagnosis and early detection of alcoholic tendencies, and on the distinguishing characteristics of the alcohol abuser.

Objectives for 1976: The FY 1976 request for grants and contracts provides continuation funding support at a reduced level for ongoing areas of major research as described above. A major expansion will take place in the alcohol intramural research program. The 1976 request provides for an increase of 16 budgeted positions to expand (1) biochemical studies to investigate the causes and treatment of alcoholic "fatty liver", cirrhosis of the liver, and points of metabolic derangements which ultimately lead to disease; (2) neuroscience studies aimed at understanding the genetic, hormonal nutritional and physiological factors which affect the activity of the brain following the intake of alcohol; (3) clinical studies which include medical and psychiatric service for alcoholic persons with chronic problems such as cirrhosis of the liver, cerebral impairment, and other targeted abnormalities; (4) psychological studies on environmental, genetic and psychological factors associated with the use of alcohol.

1/ Excludes $1,000 in 1973 appropriation restoration obligated in fiscal year 1975.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, & Mental Health

Program Purpose & Accomplishments

Activity: Alcoholism-Training - (Public Health Service Act, Section 303, National Research Service Award Act of 1974, Section 472).

1975 Estimate		1976				
					Budget Estimates	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
--	$6,564,000	PHS	303	Indefinite	--	$6,067,000
--	976,000	NRSA	472	Expired 2/	--	891,000
	7,540,000 1/					6,958,000

Purpose: This subactivity provides funds to increase the number and improve the quality of people working in the field of alcoholism and alcohol abuse.

Explanation: Training grants are awarded to public and non-profit organizations to defray institutional costs of training programs, and to provide stipends to enrolled individuals. Area Alcoholism Education and Training Programs are also supported to provide a focused assessment of the alcoholism manpower needs of the States and localities. Fellowships are awarded to predoctoral and postdoctoral research fellows working in the area of alcoholism.

Accomplishments in 1975: During 1975, the NIAAA provided continuation support to 25 training grants and 4 research fellowships. A total of 74 new and competing training grants were awarded as well as 18 new postdoctoral and 20 new predoctoral fellowships under the National Research Service Award Act of 1974.

Objectives for 1976: In 1976, the NIAAA will provide continuation funding at a reduced level to honor prior commitments. It is anticipated that a total of 130 continuation grants will be awarded, plus continuation support for 40 fellowships. Several awards are associated with projects initially funded in 1974 and 1975 with court released 1973 appropriations.

1/ Excludes $3,573,000 in 1973 appropriation restorations obligated in fiscal year 1975.

2/ Authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
Alcohol, Drug Abuse, & Mental Health
Program Purpose & Accomplishments

Activity: Alcoholism - Community Programs - Project Grants and Contracts (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, Sections 304 & 311; Community Mental Health Centers Act, Section 261).

1975 Estimate		1976				
					Budget Estimates	
Pos.	Amount	Act	Sec.	Authorization	Pos.	Amount
--	$11,051,000	CMHC	261	"Sums as nec."	--	$10,431,000
--	51,357,000	2/	311	$95,000,000	--	32,520,000
--	2,500,000		304	13,000,000	--	2,500,000
	64,908,000 1/					45,451,000

Purpose: This subactivity supports grants and contracts to reduce the seriousness, prevalence, and incidence of alcoholism through support of community treatment, rehabilitation and prevention programs.

Explanation: Project grants and contracts include a variety of programs in support of community efforts in the areas of alcohol treatment, rehabilitation and prevention.

Accomplishments in 1975: During 1975, the NIAAA made a total of 456 awards, including 309 new and competing awards. High priority areas include programs targeted to high risk, poverty and minority populations where services have traditionally been lacking. These included Indians, poverty populations, Blacks, Spanish-speaking, migrant workers and others. Emphasis was also placed on projects for drinking drivers, public inebriates, and employed alcoholics. In 1975, the NIAAA awarded a comprehensive technical assistance contract to provide close monitoring and furnish management and program assistance to grantees. In addition support was provided to 15 states for implementation of the Uniform Alcoholism and Intoxication Treatment Act.

Objectives for 1976: In 1976, the NIAAA will provide continuation support to existing grantees, at reduced funding levels. Projects in support of the Uniform Act will be continued at their 1975 funding levels. The staffing grants will be continued in accordance with their established matching rates. A total of 344 grants and contracts will be supported.

1/ Excludes $16,032,000 in 1973 appropriations restorations obligated in fiscal year 1975.

2/ Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION
Alcohol, Drug Abuse & Mental Health
Program Purpose and Accomplishment

Activity: Alcoholism - Community Programs - Grants to States (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Section 301).

1975 Estimate		1976		
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
--	$52,000,000	$80,000,000	--	$45,600,000

Purpose: Formula grants are made to the States for the planning, establishment, maintenance, coordination and evaluation of projects for the development of alcoholism treatment, rehabilitation and prevention programs.

Explanation: Funds are allotted to States on the basis of their relative population, financial need and the need for a more effective prevention treatment and rehabilitation program. Plans submitted by the States must show an assessment of need, and the specific functions to be supported under the State allotment.

Accomplishments in 1975: In 1975, an estimated 67% of formula grant dollars were directed to treatment activities in the States. The remaining funds were used in the areas of Statewide program development, education and training, prevention, evaluation and administrative costs.

Objectives for 1976: In 1976, a plan of utilization similar to that in FY 1975 is anticipated, at a reduced level.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION
Alcohol, Drug Abuse and Mental Health
Program Purpose and Accomplishment

Activity: Alcoholism - Management and Information (Public Health Service Act, Section 301).

1975 Estimate		1976		
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
125	$10,330,000 1/	Indefinite	104	$7,143,000

Purpose: This subactivity supports the overall planning, direction, and coordination of the alcoholism programs supported by the NIAAA. Also included are funds to support scientific and public information activities, program analysis and evaluation, and administrative management.

Explanation: Funding is provided for the general operation of the National Institute on Alcohol Abuse and Alcoholism, including the personnel and related costs of the individual operating programs, Institute program direction, program coordination, analysis and evaluation, and administrative management. Also included are the nationwide information collection and dissemination activities carried out by the National Clearinghouse for Alcohol Information. Finally, this subactivity provides support for the National Center for Alcohol Education.

Accomplishments in 1975: Activities aimed at increasing the nation's awareness of the risks involved in heavy drinking continued to receive major emphasis. This is carried out through a wide range of media directed to general as well as targeted audiences. The National Clearinghouse for Alcohol Information collects alcoholism literature from around the world and disseminates it to millions from all sectors of the population. The National Center for Alcohol Education brings together State Directors of alcoholism, policy makers and other leaders from across the country, who exchange information on innovative programs and legislative developments which could be broadly adapted.

Objectives for 1976: In 1976, the Institute will reduce the activities carried on be the National Clearinghouse for Alcohol Information. The budget will provide a modest level of support for the basic functions of the Clearinghouse and the National Center for Alcohol Education. Also, a number of small scale public information contracts will be discontinued, and the level of staff support reduced by $210,000.

1/ Excludes $205,000 from 1973 appropriation restoration.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Buildings and Facilities

1975 Estimate		1976 Estimate		
		Authorization	Budget Estimate	
Pos	Amount		Pos	Amount
---	($7,522,000)	Indefinite	---	(---)

Purpose: For construction, alterations, repairs, and improvements of buildings and facilities of the Alcohol, Drug Abuse, and Mental Health Administration, including preparation of plans and specifications.

Explanation: This account is used principally to fund construction, repairs and improvements at Saint Elizabeths Hospital, although work of a capital improvement nature upon other ADAMHA facilities may also be supported from these funds. Appropriations to the Buildings and Facilities activity are available until expended.

Accomplishments in 1975: Air conditioning projects are currently in various stages of completion at three facilities of Saint Elizabeths Hospital. The planning phase is complete for the unit to be installed in John Howard Pavilion; installation is commencing at Dix Pavilion, the facility which houses the Area D Community Mental Health Center; and work is almost complete at Nichols Building, one of the hospital's larger general treatment facilities. It is also expected that drawings and specifications will be commenced for air conditioning of a fourth facility, the W.W. Eldridge (Medical and Surgical) Building. Renovation of the hospital's sanitary and storm sewer facilities is expected to be completed late this fiscal year. The overhaul of wiring, plumbing, and exterior screening is currently underway in several facilities.

Objectives for 1976: No new appropriations are requested. It is anticipated that construction funds will be requested upon consummation of the transfer of Saint Elizabeths Hospital to the District of Columbia.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health Administration

Program Purpose and Accomplishments

Activity: Program Direction (Public Health Service Act, Section 301)

1975 Estimate		1976	
		Authorization	Budget Estimate
Pos.	Amount		Pos. Amount
301	$10,459,000	Indefinite	299 $11,564,000

Purpose: These funds provide support for the overall direction and management of the agency, the regional office staff, and rental payments to GSA for buildings occupied by regional office and headquarters staff.

Explanation: The functions carried out in this activity include planning and evaluation program coordination, administrative management services, and public affairs activities. Also included are operating costs of general mental health, alcoholism, and drug abuse personnel located in the DHEW Regional Offices. In addition, the Public Building Amendment of 1972 (P.L.92-313) requires each agency occupying space assigned by GSA to reimburse them for that space.

Accomplishments in 1975: Particular emphasis in FY 1975 was given to evaluation of the Agency programs and collaboration between headquarters, the regional offices, and State and local mental health agencies, as well as to issues revolving around health services funding.

Objectives for 1976: The Agency will continue its efforts in evaluation of programs, coordination and collaboration between headquarters and the regional offices, with other Federal and State agencies, and with citizens groups with regard to the delivery and the funding of mental health services.

Allocation of Funds for Drug Abuse

Formula Grants

	1975 Estimate	1976 Estimate
Alabama	$690,702	$690,702
Alaska	100,000	100,000
Arizona	344,083	344,083
Arkansas	403,908	403,908
California	3,067,911	3,067,911
Colorado	390,602	390,602
Connecticut	436,878	436,878
Delaware	100,000	100,000
District of Columbia	211,453	211,453
Florida	1,266,270	1,266,270
Georgia	851,522	851,522
Hawaii	122,569	122,569
Idaho	139,627	139,627
Illinois	1,649,820	1,649,820
Indiana	872,506	872,506
Iowa	483,328	483,328
Kansas	369,653	369,653
Kentucky	626,325	626,325
Louisiana	712,867	712,867
Maine	189,621	189,621
Maryland	618,231	618,231
Massachusetts	881,400	881,400
Michigan	1,385,539	1,385,539
Minnesota	638,902	638,902
Mississippi	480,896	480,896
Missouri	784,331	784,331
Montana	126,078	126,078
Nebraska	253,580	253,580
Nevada	100,000	100,000
New Hampshire	131,463	131,463
New Jersey	1,064,698	1,064,698
New Mexico	208,277	208,277
New York	2,626,377	2,626,377
North Carolina	959,500	959,500
North Dakota	117,323	117,323
Ohio	1,707,144	1,707,144
Oklahoma	478,256	478,256
Oregon	369,688	369,688
Pennsylvania	1,909,028	1,909,028
Rhode Island	155,852	155,852

Allocation of Funds for Drug Abuse

Formula Grants

	1975 Estimate	1976 Estimate
South Carolina	526,999	526,999
South Dakota	127,502	127,502
Tennessee	770,018	770,018
Texas	2,036,427	2,036,427
Utah	211,167	211,167
Vermont	100,000	100,000
Virginia	802,084	802,084
Washington	547,531	547,531
West Virginia	338,837	338,837
Wisconsin	755,565	755,565
Wyoming	100,000	100,000
Guam	19,525	19,525
Puerto Rico	596,413	596,413
Virgin Islands	15,356	15,356
American Samoa	6,253	6,253
Trust Territory	20,115	20,115
Total	35,000,000	35,000,000

Allocation of Funds for Alcohol Formula Grants

	1975 Estimate	1976 Estimate
Alabama	$ 1,021,776	$ 886,321
Alaska	200,000	200,000
Arizona	509,012	461,066
Arkansas	597,514	514,782
California	4,538,653	4,010,827
Colorado	577,830	510,306
Connecticut	646,287	568,499
Delaware	200,000	200,000
District of Columbia	200,000	200,000
Florida	1,873,231	1,692,067
Georgia	1,259,682	1,105,663
Hawaii	200,000	200,000
Idaho	206,555	200,000
Illinois	2,440,628	2,094,941
Indiana	1,290,725	1,114,616
Iowa	715,002	595,357
Kansas	546,839	461,066
Kentucky	926,542	801,270
Louisiana	1,054,566	913,179
Maine	280,512	250,677
Maryland	914,567	792,317
Massachusetts	1,303,881	1,145,950
Michigan	2,049,669	1,768,166
Minnesota	945,147	814,699
Mississippi	711,404	613,263
Missouri	1,160,285	1,011,659
Montana	200,000	200,000
Nebraska	375,129	317,822
Nevada	200,000	200,000
New Hampshire	200,000	200,000
New Jersey	1,575,040	1,356,340
New Mexico	308,111	273,059
New York	3,885,279	3,384,135
North Carolina	1,419,417	1,226,525
North Dakota	200,000	200,000

Allocation of Funds for Alcohol

Formula Grants

Ohio	2,525,429	2,193,421
Oklahoma	707,498	622,215
Oregon	546,890	478,971
Pennsylvania	2,824,083	2,439,621
Rhode Island	230,556	200,000
South Carolina	779,605	684,884
South Dakota	200,000	200,000
Tennessee	1,139,110	980,325
Texas	3,012,761	2,658,963
Utah	312,377	277,535
Vermont	200,000	200,000
Virginia	1,186,548	1,034,041
Washington	809,979	707,266
West Virginia	501,252	429,735
Wisconsin	1,117,730	975,848
Wyoming	200,000	200,000
Guam	28,884	22,381
Puerto Rico	882,291	756,506
Virgin Islands	22,716	17,905
American Samoa	9,251	8,953
Trust Territory	29,757	26,858
Total	$ 52,000,000	$ 45,600,000

NEW POSITIONS REQUESTED

Alcohol

Research Psychiatrist	GS-15	2	59,636
Internist	GS-15	1	29,818
Neuroscientist	GS-15	1	29,818
Biochemist	GS-14	1	25,581
Physiologist	GS-14	1	25,581
Postdoctoral Fellow	GS-14	2	51,162
Research Associate	GS-13	2	43,632
Psychology Technician	GS-11	1	15,481
Administrative Assistant	GS-9	1	12,841
Secretary	GS-7	1	10,520
Technician	GS-6	2	18,946
Secretary	GS-6	1	9,473
		16	306,908

Amounts Available for Obligation

	1976 Estimate	Interim Budget
Appropriation and Obligations.....	$653,627,000	$129,855,000

Obligations by Activity - Interim Period

	1976 Estimate		Interim Period		
	Pos.	Amount	Pos.	Amount	
General Mental Health:					
Research.....	373	$80,189,000	373	$24,300,000	A/ B/
Training.....	---	45,400,000	---	3,100,000	C/
Community Programs:					
Construction.....	---	---	---	---	D/
Staffing.....	---	135,363,000	---	38,000,000	D/
Child Mental Health	---	24,780,000	---	5,000,000	D/
Management & Info...	393	20,274,000	393	5,000,000	A/
Subtotal.....	766	306,006,000	766	75,400,000	
Drug Abuse:					
Research.....	102	31,602,000	102	3,575,000	A/ B/
Training.....	---	3,000,000	---	250,000	C/
Community Programs:					
Project Grants & Contracts.....	---	137,962,000	---	14,590,000	E/
Grants to States..	---	35,000,000	---	---	
Management & Info...	293	14,294,000	293	2,800,000	A/
Subtotal.....	395	221,858,000	395	21,215,000	
Alcoholism:					
Research.....	26	9,047,000	26	3,600,000	A/ B/
Training.....	---	6,958,000	---	2,300,000	C/
Community Programs:					
Project Grants & Contracts.....	---	45,451,000	---	22,940,000	F/
Grants to States..	---	45,600,000	---	---	
Management & Info...	104	7,143,000	104	1,400,000	A/
Subtotal.....	130	114,199,000	130	30,240,000	
Buildings & Facilities	---	---	---	---	
Program Direction.....	299	11,564,000	299	3,000,000	A/
Total.....	1,590	653,627,000	1,590	129,855,000	

A/ Research direct operations and Management and Information activities are projected at 25% of the 1976 estimate less major contracts whose renewal do not fall in the Interim Period.

B/ Funding of research grants and contracts will support normal continuation costs as well as support for number of new awards normally made during the period July 1 - September 30.

C/ Funding levels for Training Grants and Contracts reflect the phase-out of training grants. Funds for a small number of new postdoctoral fellowships are provided.

D/ Funding levels support continuation costs only, reflecting the continued phase-out policy of the CMHC programs.

E/ Funding levels provide continuation costs with some competing renewals to maintain 95,000 treatment slots.

F/ Funding levels provide continuation costs only.

Obligations by Object

	1976 Estimate	Interim Period
Total number of permanent positions	1,590	1,590
Full-time equivalent of all other positions	308	308
Average number of all employees	1,894	1,894
Personnel compensation:		
Permanent positions	$33,474,000	$8,443,000
Positions other than permanent	2,507,000	649,000
Other personnel compensation	696,000	186,000
Subtotal, personnel comp	36,677,000	9,278,000
Personnel Benefits	3,864,000	967,000
Travel & transportation of persons	2,147,000	530,000
Transportation of things	79,000	20,000
Rent, communications & utilities	6,308,000	1,532,000
Printing & reproduction	1,165,000	285,000
Other services	16,484,000	4,399,000
Project contracts	61,836,000	1,439,000
Supplies and materials	2,009,000	502,000
Equipment	1,498,000	368,000
Grants, subsidies & contributions	521,560,000	110,535,000
Total obligations by object	653,627,000	129,855,000

Justification

The funds requested for the period July 1, 1976 through September 30, 1976 will maintain the program levels supported during FY 1976. All funding policies proposed in the FY 1976 budget are extended through this Interim Period. The specific description of each activity are as follows:

1. Research Grants and Contracts: The request provides continuation costs as well as funds to support the number of new awards normally made during the period from July 1 through September 30. This request by type for each Institute is listed below:

	1976 Estimate		Interim Period	
	No.	Amount	No.	Amount
a. General Mental Health:				
Non-competing	591	$46,957,000	201	$16,000,000
Competing	213	12,542,000	47	2,800,000
Total	804	59,499,000	248	18,800,000
b. Drug Abuse:				
Non-competing	246	23,471,000	26	2,495,000
Competing	49	5,527,000	4	380,000
Total	295	28,998,000	30	2,875,000
c. Alcohol:				
Non-competing	92	6,800,000	24	2,270,000
Competing	13	1,009,000	13	1,030,000
Total	105	7,809,000	37	3,300,000

2. Training Grants and Contracts: The phase out of the training grant and contract program will continue during the Interim Period. A small number of new postdoctoral fellowships will be awarded.

	1976 Estimate		Interim Period	
	No.	Amount	No.	Amount
a. General Mental Health:				
Training Grants (non-competing)	1,293	$40,230,000	79	$2,500,000
Fellowships:				
Non-competing	389	3,867,000	50	500,000
Competing	100	1,303,000	6	100,000
Subtotal	489	5,170,000	56	600,000
Total, Training	1,782	45,400,000	135	3,100,000
b. Drug Abuse:				
Training Grants and Contracts:				
Non-competing	21	2,933,000	1	250,000
Fellowships (non-competing)	5	67,000	---	---
Total, Training	26	3,000,000	1	250,000
c. Alcohol:				
Training Grants (non-competing)	86	6,718,000	37	2,300,000
Fellowships (non-competing)	20	240,000	---	---
Total, Training	106	6,958,000	37	2,300,000

3. Community Programs: The phase-out of the CMHC Program is continued during the Interim Period. The budget requests funds for continuation costs only. Drug Abuse funding levels reflect continuation funding in support of 95,000 treatment slots and a normal number of new demonstration and prevention awards. The funding level for alcohol project grants and contracts reflects continuation funding only and is consistent with the FY 1976 Budget. No funds for formula grants are requested as these awards are normally made during the fourth quarter (March - June). The funding levels by type are as follows:

	1976 Estimate		Interim Period	
	No.	Amount	No.	Amount
a. General Mental Health:				
1. CMHC Construction.....	---	---	---	---
2. CMHC Staffing (non-competing).....	449	$135,363,000	126	$38,000,000
3. Child Mental Health (non-competing).....	139	24,780,000	28	5,000,000
Total, Community Programs....	588	160,143,000	154	43,000,000
b. Drug Abuse:				
1. Project Grants & Contracts:				
Non-competing.....	232	115,858,000	25	12,690,000
Competing.....	67	22,104,000	6	1,900,000
Total, Project Grants and Contracts.....	299	137,962,000	31	14,590,000
2. Formula Grants.....	56	35,000,000	---	---
Total, Community Programs....	355	172,962,000	31	14,590,000
c. Alcohol:				
1. Project Grants & Contracts:				
Non-competing.....	344	45,451,000	120	22,940,000
2. Formula Grants.....	56	45,600,000	---	---
Total, Community Programs....	400	91,051,000	120	22,940,000

4. Direct Operations: Funding levels provide salary costs and operating expenses at the 1976 funding level plus mandatory increases for the period of July through September. These funds are as follows:

	1976 Estimate		Interim Period	
	No.	Amount	No.	Amount
Personnel compensation & benefits	1,590	$40,541,000	1,590	$10,245,000
Other objects.....	---	37,266,000	---	8,455,000
Total.....	1,590	77,807,000	1,590	18,700,000

SAINT ELIZABETHS HOSPITAL

WITNESSES

DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH
DR. LUTHER D. ROBINSON, SUPERINTENDENT, SAINT ELIZABETHS HOSPITAL
DR. ROGER PEELE, ASSISTANT SUPERINTENDENT, SAINT ELIZABETHS HOSPITAL
JAMES E. PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
P. E. GOODY, BUDGET OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
THOMAS F. WILLIAMS, ACTING ASSISTANT EXECUTIVE OFFICER, SAINT ELIZABETHS HOSPITAL
JAMES J. O'DONNELL, BUDGET OFFICER, SAINT ELIZABETHS HOSPITAL
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLOOD. We have St. Elizabeths Hospital, and the presentation will be made by Dr. Bertram S. Brown, the Director of the National Institute of Mental Health. We will put your biographical sketch in the record, Doctor.

[Dr. Brown's biographical sketch follows:]

CURRICULUM VITAE

Name: Bertram S. Brown, M.D.

Date and place of birth: Brookyln, N.Y., January 28, 1931.

Marital status: Married 1952, four children.

Education: June 1952, B.A., Brooklyn College; June 1956, M.D., Cornell University Medical College; June 1960, M.P.H., Harvard University School of Public Health.

Postgraduate training: July 1956 to June 1957, intern, Yale University School of Medicine, department of pediatrics.

July 1957 to June 1960, resident and teaching fellow (psychiatry), Harvard Medical School (Boston Psychopathic Hospital), Massachusetts Mental Health Center.

Certification: Diplomate, American Board of Psychiatry and Neurology, 1963.

Experience: July 1958 to November 1959, senior psychiatrist, Division of Legal Medicine, Commonwealth of Massachusetts; director of psychiatry, Norfolk Prison Colony.

April 1960 to present, U.S. Public Health Service, National Institute of Mental Health:

April 1, 1960 to July 4, 1961, 1. Staff psychiatrist, Mental Health Study Center;

July 5, 1961 to October 14, 1963, 2. Special assistant for program, extramural programs;

October 15, 1963 to March 22, 1964, 3. Special assistant for program, Office of the Director;

March 23, 1964 to June 5, 1966, 4. Chief, Community Mental Health Facilities Branch;

June 9, 1966 to December 31, 1966, 5. Associate Director for mental health service programs;

January 1, 1967 to June 2, 1970, 6. Deputy Director, National Institute of Mental Health;

June 3, 1970 to present, 7. Director, National Institute of Mental Health.

October 1961 to October 1962, Staff Director, President's Panel on Mental Retardation. (See: Report to the President, "A Proposed Program for National Action to Combat Mental Retardation," PPMR, U.S. Government Printing Office, Washington, D.C., October 1962.)

December 1962 to July 1963, Deputy Special Assistant to the President for Mental Retardation, The White House.

November 1970 to September 1972, Special Assistant to the Secretary of HEW for Drug Abuse Prevention.

November 1971 to July 1973, Deputy Administrator for Mental Health, Health Services, and Mental Health Administration, HEW.

Special missions: September 1972, headed NIMH delegation to the Soviet Union; May 1973, headed NIMH delegation to Japan for United States-Japan mental health mission.

Consultant (White House): June 1961 to present, President's Committee on Employment of the Handicapped;

July 1963 to July 1966, Office of the Special Assistant to the President for Mental Retardation;

July 1966 to July 1967, President's Commission on the Administration of Law Enforcement and Justice;

April 1968 to November 1969, President's Commission on the Causes and Prevention of Violence;

January 1970 to June 1970, executive secretary, the President's task force on the mentally handicapped.

Consultant (partial listing): October 1959 to April 1960, research consultant, Cambridge services for retarded children, children's bureau demonstration project, Cambridge Health Department, Massachusetts;

1960 and 1961, Outdoor Resources Recreation Review Commission, Washington, D.C.;

1962 to present, Technical Advisory Board, Maurice Falk Medical Foundation, Pittsburgh, Pa.;

April 1969 to present, task force to develop policy recommendations on health aspects of malnutrition, USPHS;

June 1969 to present, U.S. Committee on the International Congress on Social Welfare;

1970 to present, Hogg Foundation National Advisory Council.

Academic teaching appointments: July 1958 to June 1960, field work supervisor, Department of Social Relations, Harvard University;

1958 and 1959, faculty, Boston University Institute on Rehabilitation of the Emotionally Handicapped;

January 1962 to 1972, associate clinical professor of psychiatry, George Washington University Medical School;

January 1971 to present, clinical professor of psychiatry and behavioral sciences, George Washington University Medical School;

January 1965 to present, senior faculty, Washington School of Psychiatry.

Military service: U.S. Air Force, May 1957 to March 1960. First lieutenant, Inactive Reserve.

Honors and awards: Phi Beta Kappa (Brooklyn College); Alpha Omega Alpha (Cornell); Delta Omega (Harvard); Commendation Medal, U.S. Public Health Service Commissioned Corps, January 1967; Arthur S. Flemming Award, February 1969; Maryland Mental Health Citizens Award, May 1969; Anchor Club Award, June 1972; Meritorius Service Medal, U.S. Public Health Service, June 1973.

Professional societies: American Board of Psychiatry and Neurology (diplomate); American Psychiatric Association (fellow); American Public Health Association (fellow); American Orthopsychiatric Association (fellow); Council on National and International Affairs (fellow); American College of Psychiatrists (fellow); American Sociological Association; American Association on Mental Deficiency; American Medical Association.

General Statement

Mr. Flood. And I see you have a statement here. Do you want to insert that and I will ask you questions?

Dr. Brown. I prefer to insert it for the record.

Mr. Flood. All right; we will do that.

[Dr. Brown's complete statement follows:]

Mr. Chairman and members of the committee, I am grateful for the opportunity to appear today, to discuss the operations of St. Elizabeths Hospital. I have with me today the Superintendent of the hospital, Dr. Luther D. Robinson.

St. Elizabeths Hospital provides treatment and rehabilitation for approximately 10,000 patients a year. At any time during the year, an average of approximately 2,850 of these patients actually reside in the hospital, with an equal number carried as outpatients. The hospital offers a wide selection of treatment programs:

A community mental health center provides a full range of services to District of Columbia residents who live in the southeast quadrant of the city;

A forensic program provides treatment and determines competency to stand trial, for patients admitted under various forms of criminal proceedings;

The hospital operates various treatment programs for narcotic addicts and alcohol abusers;

Special treatment services are provided for the mentally ill who are also deaf;

Special programs are available for mentally ill children;

Comprehensive medical and surgical care is provided for all patients who require it.

The hospital provides treatment, care, and rehabilitation services for a variety of patient categories including District of Columbia residents, persons charged with or convicted of crimes in the United States or District of Columbia courts, U.S. nationals who become mentally ill while abroad, residents of the Virgin Islands and U.S. Soldiers' Home, and other categories of Federal beneficiaries. Facilities of the hospital include a forensic psychiatry and security unit for the examination, treatment, and rehabilitation of patients referred by the courts under various types of criminal proceeding, and a comprehensive community mental health center.

Continued efforts to improve treatment, especially for new patients, to speed the return of patients to the community have sustained the sharp reduction in the average length of hospitalization experienced in recent years. The median time spent on the hospital rolls by patients who were released from residence during 1974 was 3.8 weeks. The median time since admission for those patients on the end of year rolls has dropped during the last 8 years from nearly 9.5 years to 4.3 years at the end of 1974. A concentrated effort has also been made to return patients to the community after hospitalization is no longer necessary.

Members of the professional staff, both officially and individually, provide consultative and educational services on request to D.C. community agencies and personnel. The hospital also cooperates with local agencies and local mental health associations in finding jobs for former patients.

The 1976 request continues the hospital's ongoing clinical training and research programs. A principal objective of the training programs is to increase the number and improve the skills of persons serving medical, nursing, and allied mental health disciplines related to the treatment and rehabilitation of the mentally ill. In 1976, the hospital will provide year-round training to students from local medical schools, and will support graduate and postgraduate programs in mental health disciplines related to the treatment and rehabilitation of the men-for physicians. In addition, training will be provided for other mental health professionals in the disciplines of dentistry, nursing, psychodrama, social service, clinical psychology, group traning, chaplaincy, dance therapy, and volunteer services. Special workshops on community mental health will be provided, and extensive training will be conducted for groups from the community served by the Hospital. The training programs serve as a critical source of recruitment for scarce-category medical officers and other related professional staff. The ongoing research programs will continue to provide a better understanding of our patients and methods of serving the patients.

The hospital also supplies the clinical base for the provision of accredited course work for students from local schools and universities in the fields of medicine, social work, clinical psychology, mental health counseling, psychodrama, recreational therapy, vocational rehabilitation, chaplaincy, and nursing. St. Elizabeths also provides formal orientation in mental health concepts to law enforcement personnel from national, State and local agencies, and the clergy.

This budget request of $75,186,000 represents an increase of $4,682,000 over fiscal year 1975. These additional funds consist of primarily full-year pay act costs as well as related cost of living increases necessary for the maintenance and operation of the St. Elizabeths Hospital for fiscal year 1976.

In response to the request of the committee, we have prepared this budget on the basis of continued Federal control of the hospital. The Department will, however, be submitting legislation, in the near future, proposing transfer of St. Elizabeths to the District of Columbia.

Mr. Chairman, I will be pleased to respond to any questions you might have.

Mr. FLOOD. By the way, what is the status of the legislation as of today, if you know, on the transfer of St. Elizabeths to the District of Columbia?

Dr. BROWN. Under preparation, Mr. Chairman.

ACCREDITATION

Mr. FLOOD. All right, Doctor, has St. Elizabeths received full accreditation from the Joint Commission on the Accreditation of Hospitals?

Dr. BROWN. For the past 2 years it has received temporary accreditation for 1-year status and is due to have another accreditation survey 1 month from now.

Mr. FLOOD. Suppose you outline briefly for us the deficiencies cited by that Joint Commission on the Accreditation of Hospitals. This is the last survey made by JCAH?

Dr. BROWN. I would like, at this point, to introduce Dr. Luther Robinson, who is not just in charge of deficiencies, but assets as well.

Mr. FLOOD. Suppose you introduce the rest of them too, left and right, and then we can have biographical sketches of them placed in the record as soon as they talk. We would like to have those sketches.

Dr. BROWN. Very briefly, Luther Robinson is Superintendent, whom you have met several times. James O'Donnell, budget officer, and Dr. Roger Peele, the Assistant Superintendent of St. Elizabeths. Mr. Jim Pittman is Executive Officer of the National Institute of Mental Health and Ed Goody is the budget officer of the National Institute of Mental Health.

Before I give him the ball, I want to say that Dr. Robinson has been honored for his work with the deaf and mentally ill deaf. He received his doctorate from Gallaudet.

Mr. FLOOD. We know the doctor. All right, Doctor.

Dr. ROBINSON. Thank you, Mr. Chairman.

In responding to your question about the deficiencies as far as accreditation is concerned, from the survey by the Joint Commission on Accreditation of Hospitals of last June, three major areas of deficiency were mentioned. The first was in environment; the second, the governing body and management; and third, patient safety.

I would like to point out first, deficiencies in environment, and I will just read these briefly. Sleeping facilities to provide appropriate privacy for each patient; every resident should have ample closet and drawer space in which to keep his private property, especially in regard to geriatric units; nursing stations should be open to promote better interaction between staff and residents; laundry rooms in which patients may wash their own clothing should be available; privacy should be provided for personal hygiene; and all areas should be free of undesirable odors.

Now, I might say that our hospital, being about 120 years old, was not built particularly with the kind of treatment and care in mind which the Joint Commission on Accreditation of Hospitals requires of this particular era, and, therefore, major changes in the structural environment need to be brought about in order to bring conditions into compliance with the standards.

Mr. FLOOD. Suppose you were to lose your accreditation; what would the impact be on recruitment and reimbursement, your third-party reimbursement, teaching programs?

Dr. ROBINSON. All of these would be disastrous, very disastrous.

Mr. FLOOD. You just started, but for the record you give us a list of all those divisions, will you——

Dr. ROBINSON. Very well.

Mr. FLOOD [continuing]. That were cited by the JCAH and indicate the cost of correcting each one of the deficiencies as best you can and also how much time do you have to correct these deficiencies before your accreditation is withheld; what is the time element? You can do that for the record.

Dr. ROBINSON. Yes.

[The information follows:]

SAINT ELIZABETHS HOSPITAL
Correction of Accreditation Deficiencies

The Joint Commission on Accreditation of Hospitals (JCAH), upon the recommendation of the Accreditation Council for Psychiatric Facilities and the Hospital Accreditation Program has accredited Saint Elizabeths Hospital provisionally - for a period of one year (June 28, 1974 - June 27, 1975). Standard, full accreditations are two years in length. Provisional accreditations are approved for periods of one year at a time and are issued when an institution, failing to come up to full accreditation standards, requires a substantial period of time to correct deficiencies. A maximum of three provisional accreditations may be authorized. Saint Elizabeths is now operating under its second. By June of 1975, Saint Elizabeths Hospital must either have fully complied with JCAH recommendations, or be able to demonstrate that specific corrective measures are now under way.

The recommendations of the JCAH survey were very general in nature. In order to translate the recommendations into a specific, quantifiable request, a follow-up inspection of the physical plant was conducted by qualified architectural and engineering staff. The survey team included representatives of the Division of Health Facilities Planning, PHS; Division of General Services ADAMHA; and engineering staff from the Hospital. Representatives of NIMH staff also consulted with the team. The JCAH survey developed recommendations to achieve four general objectives:

1. Relief of patient overcrowding;
2. Improvement of safety;
3. Achievement of more privacy for patients; and
4. Improvement of services to patients.

The JCAH survey also alluded to deficiencies with respect to staff, stating that "... the governing body should make available the resources necessary to recruit a sufficient number of qualified personnel to meet the needs of the patients". The staffing implications of the JCAH survey are still under study, and a firm personnel estimate is not available at this time. However, the facility needs have been priced out and are set forth in the material which follows:

Saint Elizabeths Hospital
Accreditation Deficiencies

Deficiency & Action Recommended	Estimated Cost
I. Reduce overcrowding in Patient residential facilities: Construct or renovate sufficient residential facilities to house 800 additional patients. Precede construction with a master site plan.	
A. Site plan	$125,000
B. Additional or Renovated Facilities:	
1. Plans and specifications	2,920,000
2. Construction	46,400,000
Total to relieve overcrowding	49,445,000
II. Improve safety:	
A. Emergency lighting	120,000
B. Fire detection and alarm system	1,410,000
C. Sprinkler systems	130,000
D. Additional fire alarm boxes	50,000
E. Exhaust hood fire extinguishers	25,000
F. Fireproof drapes and curtains	185,000
G. Soiled linen containers	50,000
Total to improve safety	1,970,000
III. Improve patient privacy:	
A. Improve patient areas	645,000
B. Install closet and drawer equipment	235,000
C. Shower privacy	15,000
Total to improve privacy	895,000
IV. Improve services for patients:	
A. Nursing station modifications	320,000
B. Laundry rooms and equipment	105,000
C. Improve pharmacy	25,000
Total, improve service for patients	450,000
Total estimated cost of accreditation related improvements (excluding staff)	52,760,000

OPERATING DEFICIT

Mr. FLOOD. On March 29, 1975, there was an article in the Washington Post announcing that St. Elizabeths Hospital was preparing to cut the staff because of the impending deficit. I tore that out right away, and I guess you saw that. What is the situation at the moment?

Dr. BROWN. The situation at the moment is that a deficiency in cost of running the hospital is perhaps going to be submitted for a supplemental request. There are no plans to furlough any employees. This was one of the contingency plans if we had absolutely to stay within our budget and there was no other way to handle the situation.

Mr. FLOOD. Has OMB approved your submission?

Mr. MILLER. They have, and we have sent a letter to the Senate, a copy of which you have, asking them to put the money in the second supplemental, which you have already acted on.

Mr. FLOOD. Knowing you like I do, you avoided telling me how much. How much for 1975?

Mr. MILLER. $1,058 million. The President will send a message up on it.

STAFFING

Mr. FLOOD. What is your end-year employment ceiling for 1975?

Dr. ROBINSON. I would like to turn to Mr. O'Donnell.

Mr. O'DONNELL. 3,911.

Mr. FLOOD. How does that compare with the end-year situation for 1974?

Mr. O'DONNELL. The end of year employment ceiling for 1974 was 3,991, Mr. Chairman.

Mr. FLOOD. How much more money would you need in the 1976 budget in order to restore your employment ceiling to that June 1974 level?

Mr. O'DONNELL. Actually, I think the money aspect is not the problem——

Mr. FLOOD. It is here before the Appropriations Committee.

Mr. O'DONNELL. About an average salary of $13,000, so with 100 positions we are talking about $1.3 million.

FINANCING

Mr. FLOOD. We talked about that other project. What is your major source of non-Federal reimbursements?

Mr. O'DONNELL. Non-Federal reimbursement really is the District of Columbia, Mr. Chairman.

Mr. FLOOD. What per diem rate do you charge the District of Columbia?

Mr. O'DONNELL. The per diem rate is spelled out in the District of Columbia's appropriation language of $24.53 per day.

Mr. FLOOD. What per diem rate do you charge to other third parties?

Mr. O'DONNELL. I believe that per diem rate is $64.76.

Mr. FLOOD. Why is there such a wide spread in that per diem charge between D.C. and other third parties? That is quite a spread.

Dr. BROWN. A bit of the history of that; as you know for many years it was calculated by the District reimbursing St. Elizabeths according to the top five States. Several years ago, this was frozen at a given level and has stayed there while costs have escalated across all mental health hospital costs.

Mr. FLOOD. If you could close that gap, this per diem charge, would you eliminate the deficit you are talking about for fiscal 1975? You would, wouldn't you?

Mr. O'DONNELL. No, sir, Mr. Chairman. The deficit is really being made up, the difference between the two——

Mr. FLOOD. If you close the gap, couldn't you wipe out the deficit for 1975?

Mr. O'DONNELL. The deficit is not attached to the per diem rate, Mr. Chairman. The deficit is really attached to the total appropriation level which the hospital is authorized.

Mr. FLOOD. Now, this budget you have before us now, will that permit the hospital in 1976 to operate without cutting back on services now across the board?

Dr. BROWN. It will permit the current budget essentially the same——

Mr. FLOOD. Not the current one, but the one before us.

Mr. BROWN. It will permit essentially the same level of service without any significant improvement. And the improvement is needed.

Mr. FLOOD. I am saying, will the budget before us today, is that going to cut back services? Will you be able to operate without cutting back services in 1976?

Dr. BROWN. I think there will have to be some services cut back, but I couldn't say how much.

Mr. FLOOD. Thank you very much.

Mr. Conte.

TRANSFER TO DISTRICT OF COLUMBIA

Mr. CONTE. Dr. Brown, it seems that the Department has been trying to transfer St. Elizabeths to the District of Columbia for some time. It also seems that the District is reluctant at best to accept that transfer. Can you tell me why no one seems to want St. Elizabeths Hospital? What's wrong with it?

Dr. BROWN. The administration has been proposing to transfer the hospital to the District because it is felt that this is the most logical place for the hospital. We would be reluctant to speak for the District, but we understand that they have officially tended to support the concept of the transfer also. The issue is really one of timing. Although we favor locating the hospital within the District, we welcome the opportunity to continue working with the hospital until transfer is achieved. St. Elizabeths is like a lot of other institutions, in the sense that it has problems. However, it also has many fine programs of which we are proud, and we expect the hospital to continue its strides in alleviating inadequacies and developing quality programs.

REFERRAL SYSTEM

Mr. CONTE. Your justification states that the forensic services program is being improved through a more selective referral system from the District of Columbia. If people are not referred to St. Elizabeths,

are there other institutions in the city capable of determining competency to stand trial? By what criteria is the referral system becoming more selective?

Dr. BROWN. As a result of the leadership of Judge Ugast of the District of Columbia Superior Court, and his chairmanship of a Forensic Liaison Committee which has met regularly since a crisis in the summer of 1974, a specific screening program under the District of Columbia Forensic Unit is now operational. Under ordinary circumstances, a psychiatrist from the District of Columbia Forensic Unit is responsible for conducting a screening examination for competency to stand trial, and may determine competency as a result of this examination. However, if the defendant presents unusually difficult evaluation problems, or is in need of psychiatric hospitalization, the District of Columbia forensic psychiatrist recommends hospitalization at St. Elizabeths Hospital for more thorough and/or psychiatric treatment. The routine court order from the District of Columbia Superior Court is now structured to automatically include this two-stage procedure when needed.

There is still a provision for judges to bypass this screening procedure, however, and order the defendant directly to St. Elizabeths Hospital for examination and report.

There are other institutions besides the District of Columbia Forensic Unit and St. Elizabeths Hospital that could potentially be utilized to determine competency to stand trial, but none of these are now providing such services. These include the community mental health center and private psychiatric facilities who might be willing to do some examinations on a contract basis.

For many years, the District of Columbia General Hospital psychiatric unit did all competency examinations on patients charged with misdemeanors. This service is no longer available, and the evaluation is now carried out by St. Elizabeths Hospital.

CMHC SERVICES

Mr. CONTE. Would you outline the CMHC services provided for District of Columbia residents of area D?

Dr. BROWN. I would like to respond to that question by placing a short statement into the record.

[The information follows:]

COMMUNITY MENTAL HEALTH SERVICES FOR AREA D

The Area D Community Mental Health Center is operated by and located on the grounds of St. Elizabeths Hospital. It serves the greater Anacostia section of Southeast Washington, D.C., one of four health service areas of the District known as Area "D." It has a population of about 180,000. The Area D CMHC currently has about 1,400 patients on its rolls, of whom 1,200 are outpatients. The Center operates without a waiting list and does not use the other divisions of the hospital as backup services.

The Area D Community Mental Health Center has four general psychiatric treatment units, which conceptually are themselves minicenters. Each general unit consists of an outpatient team, an inpatient service, and shares with the rest of the hospital the 24-hour Emergency and Admissions Service. These general units operate without waiting lists and are responsible for all psychiatric admissions or registrations from their respective subcatchment sections of Area D. In addition, they establish ties with local agencies, such as the schools, in their respective areas and provide consultation and educational services to agencies

or communtiy groups as well as direct clinical outreach services in such neighborhood health centers as may be developed from time to time. The general units operate without a waiting list and offer comprehensive treatment facilities such as individual psychotherapy, group psychotherapy, family therapy, a day treatment program, vocational rehabilitation, recreational therapy, occupational therapy, pastoral counseling, et cetera. They also have specialized outpatient groups for alcoholics, families, and children, et cetera.

In addition to these general psychiatric services, the Area D CMHC operates long-term voluntary specialized programs for male and female alcoholics, children, adolescents, and drug abusers. Two public-school teachers are assigned by the D.C. Board of Education to teach children and adolescents in our programs.

The Area D Community Mental Health Center has a full-time staff of 206 professionals and supporting personnel. This staff is supplemented on a part-time basis by various specialized programs at the hospital such as psychodrama and Volunteer Services. The Center also serves as a base for a number of training programs including psychiatric residents, social workers, nurses, psychologists, chaplains, et cetera.

The Center has an elected Citizens Board composed of residents of Area D which furnishes policy and program guidance to the staff of the Center.

IMPROVEMENTS IN TREATMENT

Mr. CONTE. Could you tell me what sorts of improvements in treatment have enabled you to reduce the average length of hospitalization?

Dr. BROWN. There are a great many factors. The medications we are using are more effective. Higher staff-to-patient ratios, and improved employee training and skill development programs, have helped. Auxiliary services such as psychodrama and pastoral counseling have been expanded. There are also more resources available to care for patients outside of the hospital. There are other factors which do not relate specifically to improvements in the state of the art. For example, the hospitalization of patients against their will is now subject to more legal safeguards than it was 12 or 15 years ago. Finally, although it is difficult to document, it appears that public acceptance of what was once considered unorthodox behavior has increased.

TRAINING

Mr. CONTE. I think it is interesting that St. Elizabeths will be providing training in mental health, as well as graduate and postgraduate programs in mental health professions. As I recall, the ADAMHA budget is phasing out all training support. Is that correct, and can you explain why we should support training in this particular hospital and not in the mental health program as a whole?

Dr. BROWN. I am glad to have this opportunity to make a very important distinction. As you know, it is not the policy of the administration to "stamp out" mental health training. Rather, the issue is one of shifting the funding for such programs to the non-Federal sector or, at the very least, to other Federal programs which are based upon concepts of payback and national need. St. Elizabeths is unique in this respect, whether it is transferred to the District of Columbia or not. If the hospital is transferred to the District, we have an obligation to keep its training capacity intact so that the District will have the prerogative of picking up this program if it wishes. If the hospital has several more years of Federal control, we also have a very special obligation, because St. Elizabeths does not have access to the various alternate sources of funding that would be available to other teaching

hospitals. The loss of its training capacity would also place the hospital in a very serious situation with respect to accreditation and ability to recruit quality professional staff.

UNITIZATION

Mr. CONTE. Can you explain for me how the unitization of the hospital has worked, and the rationale for the unitization?

Dr. BROWN. The rationale for unitization is to make every member of the treatment team personally accountable for the recovery of specific patients. A person who is admitted to a unitized hospital is treated by the same group of people from the time he is first admitted until the end of his outpatient status. As a result, the effectiveness of each unit can be measured by the success of its treatment programs. Typically, old-line State hospitals were organized by discipline. Doctors reported to doctors, nurses were accountable to other nurses, and so on. In many respects, the structure resembled an assembly line. While the staffs were just as dedicated as they are now, the system made it difficult to relate to individual patients or to plot a course of treatment smoothly. How has unitization worked? I would say very well indeed. St. Elizabeths has shown a remarkable record for reducing its inpatient load despite a soaring admission rate, and despite the fact that many of the patients now being returned to the community were once considered incurable. We have also received praise from accreditation groups for the extraordinary level of dedication among the hospital staff, and for the fact that even the maintenance and administrative staff are personally involved in the treatment of patients.

NARCOTIC ADDICTION PROGRAM

Mr. CONTE. Can you tell me about your narcotic addiction program? How many people do you expect to reach with this program in 1976? How many people in area D would you estimate are in need of such a program who do not have access to one?

Dr. BROWN. I would like to respond to that question by inserting, in the record, a short statement which deals with those points.

[The information follows:]

NARCOTIC TREATMENT PROGRAMS AT ST. ELIZABETHS HOSPITAL

Drug abusers are treated both on the general psychiatric wards for acute problems and in the drug-free therapeutic community, known as "Last Renaissance." This is a voluntary long-term program. A summary of its services follows:

PROGRAM DESCRIPTION

The drug program of the Area D Community Mental Health Center includes detoxification and rehabilitation. Detoxification is done on a 5-day basis, utilizing Methadone in decreasing amounts to ease the discomforts of withdrawal. Detoxification is performed on the four admission wards of the Area D Community Mental Health Center.

The rehabilitation program consists of a drug-free therapeutic community where addicts, following detoxification, live and work 24 hours a day. Program expansion potential is to treat 75 addicts.

TREATMENT

The major therapeutic tool is the Encounter a group designed to develop awareness as to how the individual is seen by other members of the group and as an outlet to release hostility, verbally. The Encounter is held three times a week.

The Statis Probe, held once every 2 weeks, is an intimate, sensitivity-type of small group activity in which participants reveal their problems and get help from each other in the form of empathy and shared insights.

Another therapeutic tool is the Seminar, a daily group designed to provide education and promote increased self-confidence. Seminars include lectures, discussions on current events, and practice in public speaking.

Assigned tasks, ranging from housekeeping to program coordinating, are also part of the therapeutic process.

GOAL

The goal of Last Renaissance Drug-Free Therapeutic Community is to return mature and responsible individuals to the community, who are able to live drug-free, self-sustaining lives.

GRADUATION

Requirements for graduation from the program are: (a) involvement in appropriate educational or vocational activity; (b) participation in the program for at least 12 months; (c) satisfactory indications of emotional growth and development; (d) performance as coordinator for at least 3 months.

ELIGIBILITY

Any resident of health area D, male or female, (Far Southwest, and the part of Southeast which is located south of the Anacostia River, in the District of Columbia), who is 16 years of age or older, who has a drug addiction problem and wants to stop using drugs.

STAFF

The staff consists of one psychiatrist, one trained ex-addict consultant, four trained ex-addict counselors, three registered nurses and ten nursing assistants.

Staff and residents of Last Renaissance are availabe to provide a variety of consultative and educational services to the community.

REFERRALS

Referrals to the program are made through the inpatient and outpatient services of the Area D Community Mental Health Center. Referrals through the inpatient and outatient services are made by calling the central admission unit. Telephone number 562–6500. Inquiries from other agencies concerning the program or the procedure for making a referral are welcomed.

SERVICES RENDERED

Since the program began in 1970, 388 people have been admitted; 206 have been discharged and 36 have graduated, many of whom are now serving as professional counselors in similar programs across the country. The program has currently 42 participants of whom 28 are living in the program's facilities, while 14 are living in the community and working or studying in a transition phase towards completon of the Program.

AVAILABILITY OF SERVICE AND EXTENT OF NEED

There is no precise basis for estimates of the number of people from Area D in need of such a program, but Southeast Washington is an endemic area for drug abuse. Staff members of the Last Renaissance program for drug abusers at the Area D Community Mental Health Center estimate that 300–500 people have such a problem who are not currently seeking help.

All of these people have access to the program should they seek it. This program, along with other programs of the area D CMHC, are well known in the community and there are continuing public education efforts within area D to inform citizens of the availability of these services.

It is anticipated that the current rate of admissions (about 50 per year) will continue. No one seeking assistance is turned away from the program and at the present time it has no waiting list, although about 1 year ago it had a waiting list of 10 to 15 people.

Mr. CONTE. Thank you.

Mr. FLOOD. That concludes this hearing. Thank you, Dr. Brown.

Dr. BROWN. Thank you, Mr. Chairman.

Justification of the Budget Estimates

Appropriation Estimate

Saint Elizabeths Hospital

For expenses necessary for the maintenance and operation of the hospital, including clothing for patients, and cooperation with organizations or individuals in the scientific research into the nature, causes, prevention, and treatment of mental illness, [$42,340,000] *$48,064,000* or such amount as may be necessary to provide a total appropriation equal to the difference between the amount of the reimbursements received during the current fiscal year on account of patient care provided by the hospital during such year and [$66,233,000] *$75,186,000.*

For expenses necessary for the maintenance and operation of the hospital, including clothing for patients, and cooperation with organizations or individuals in the scientific research into the nature, causes, prevention, and treatment of mental illness, $15,500,000 or such amounts as may be necessary to provide a total appropriation equal to the difference between the amount of the reimbursements received during the period of July 1, 1976, through September 30, 1976 on account of patient care provided by the hospital during that period and $20,500,000. 1

[For an additional amount for "Saint Elizabeths Hospital" $1,789,000 or such amount as may be necessary to increase total funds available to the hospital by $1,811,000, including reimbursements. (Department of Health, Education, and Welfare Appropriation Act, 1975; Supplemental Appropriation Act, 1975.)] 2

Explanation of Language Changes

1. This language permits implementation of the Congressional Budget Act of 1974 which changes the beginning of the fiscal year to October 1.

2. Full year costs relating to the 1974 supplemental have been subsumed in the 1976 basic appropriation request.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

Amounts Available for Obligation

	1975 Estimate	1976 Estimate
Appropriation	$45,240,000	$48,064,000
Proposed supplementals*	2,430,000	---
Subtotal, adjusted appropriation	47,670,000	48,064,000
Receipts and reimbursements from:		
Federal funds	847,000	919,000
Trust funds	300,000	300,000
Non-Federal sources	21,687,000	25,903,000
Total, obligations	70,504,000	75,186,000

* Includes proposed supplementals of $2,296,000 for pay costs, and $134,000 for increased health benefits costs. An additional $30,000 will be available from increased reimbursement earnings to fund the remaining pay raise requirements.

Summary of Changes

1975 Estimated obligations	$70,504,000
1976 Estimated obligations	75,186,000
Net Change	+4,682,000

	1975 Base Pos.	1975 Base Amount	Change From Base Pos.	Change From Base Amount
Increases				
A. Built-in:				
1. Annualization of pay increases	---	---	---	$3,196,000
2. Other (including Cost of Living increases, one extra day of pay above 1975 base)	---	---	---	1,486,000
Total, increases	---	---	---	4,682,000

Explanation of Changes

Increases:

A. Built-in:

1. Increases in the pay costs for annualization of General Schedule and Wage Grade pay increases effected October, 1974.

2. Additional funds are required for cost of living increases (fuel oil for heating, supplies, utilities, contractual services, equipment), within grade increases, one extra day of pay above the 1975 base.

Obligations by Activity

	1975 Estimate Pos.	1975 Estimate Amount	1976 Estimate Pos.	1976 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
Clinical and Community Services	4,028	$70,504,000	4,028	$75,186,000	---	+$4,682,000

Obligations by Object

	1975 Estimate	1976 Estimate	Increase or Decrease
Total number of permanent positions	4,028	4,028	---
Full-time equivalent of all other positions	134	134	---
Average number of all employees	4,125	4,105	-20
Personnel compensation:			
Permanent positions	$48,292,000	$50,680,000	+$2,388,000
Positions other than Permanent	1,691,000	1,621,000	-70,000
Other personnel compensation	3,365,000	3,327,000	-38,000
Special personal service payments	532,000	485,000	-47,000
Subtotal, personnel compensation	53,880,000	56,113,000	+2,233,000
Personnel benefits	4,776,000	5,175,000	+399,000
Travel and transportation of persons	230,000	242,000	+12,000
Transportation of things	86,000	86,000	---
Rent, communications and utilities	1,247,000	1,384,000	+137,000
Printing and reproduction	56,000	56,000	---
Other services	1,958,000	2,124,000	+166,000
Supplies and materials	7,154,000	8,494,000	+1,340,000
Equipment	963,000	1,307,000	+344,000
Lands and structures	176,000	227,000	+51,000
Claims and indemnities	4,000	4,000	---
Subtotal	70,530,000	75,212,000	+4,682,000
Deduct charges for quarter	-26,000	-26,000	---
Total obligations by object	70,504,000	75,186,000	+4,682,000

SAINT ELIZABETHS HOSPITAL

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation 1/
1966	10,084,000	10,217,000	10,217,000	10,290,000
1967	9,073,000	9,906,000	9,906,000	10,171,000
1968	9,044,000	9,028,000	9,028,000	10,749,000
1969	11,077,000	11,077,000	11,077,000	13,380,000
1970	10,405,000	10,405,000	10,405,000	16,883,000
1971	14,823,000	14,823,000	14,823,000	23,796,000
1972	23,144,000	23,144,000	23,144,000	27,947,000
1973	30,664,000	30,664,000	30,664,000	37,721,000
1974	38,000,000	38,000,000	38,000,000	40,875,000
1975	44,129,000	44,129,000	44,129,000	44,129,000
1975 2/	2,430,000			
1976	48,064,000			

1/ Differences between appropriation amounts and House and Senate allowances are partially due to changes in estimated patient load.

2/ Includes proposed supplemental of $2,296,000 for pay costs, and $134,000 for increased health benefits costs. An additional $30,000 will be available from increased reimbursement earnings to fund the remaining pay raise requirements.

SIGNIFICANT ITEMS IN HOUSE AND SENATE

APPROPRIATIONS COMMITTEE REPORTS

Item	Action taken or to be taken
1975 House Report	
1. Committee expressed doubt that transfer of hospital to District was any closer than in previous year.	1. At time of hearings, legislation was before Congress for transfer of hospital to District of Columbia. Legislation expired at close of 93rd Congress. Legislation will be re-introduced this session.
1975 Senate Report	
1. Committee expressed skepticism of plans for transfer of hospital to District of Columbia.	1. Action same as in response to House report.

Justification

Saint Elizabeths Hospital

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	4,028	$58,656,000	4,028	$61,288,000	---	+$2,632,000
Other expenses	--	11,874,000	--	13,924,000	---	+2,050,000
Deduct charges for quarters	--	-26,000	--	-26,000	---	---
Total	4,028	70,504,000	4,028	75,186,000	---	+$4,682,000

Authorization: Title 24 U.S. Code, Chapter 4, Sections 161 - 222.

General Statement

This appropriation supports the operation of the Saint Elizabeths Hospital, which provides treatment and rehabilitation of the mentally ill for approximately 2,850 inpatients and 2,850 outpatients. The Hospital operates a community mental health center which serves District of Columbia residents in the southeast quadrant of the city, south of the Anacostia River, commonly referred to in this context as "Area D". The 1976 Budget requests a total authorized program of $75,186,000, an increase of $4,682,000 over a current year estimated obligation level of $70,504,000.

Clinical and Community Services

Over 10,000 patients were treated at Saint Elizabeths last year. However, by providing more intensive early inpatient care and through continued emphasis on the early return of patients to productive community life, the Hospital was able to discharge a record high 3,942 patients and to achieve a reduction of over 100 in the average daily patient load.

In its continuing effort to provide better services to its patients, the Hospital made the following improvements:

(a) Unitization. The Hospital continued with the unitization of services to patients. Actions were taken to further the reorganization of the Hospital into a number of semi-autonomous patient services, each having treatment teams with the necessary staffing to provide a full range of mental health services and continuity of care for patients within its own geographic catchment area.

(b) Special Programs. The narcotic addiction program, a drug free therapeutic community known as Last Renaissance, is being expanded to serve approximately 75 patients. There have been 367 admissions into this program in fifty months. Thirty-six patients have graduated, with eighteen graduates now employed in drug rehabilitation centers throughout the country.

(c) Intensive care units. A medical and surgical intensive care suite is being established to accomodate intensive care, post surgery and post anesthesia, and isolation units.

(d) Service to children. Services to a selected group of mentally ill youngsters were expanded to cover approximately 60 patients.

(e) Forensic Services. This program, under which the number of cases to determine competency to stand trial has rapidly increased, is being improved through a more selective referral system from the District of Columbia.

Patient Profile

The median time spent on the Hospital rolls by patients who were discharged from residence during 1974 was 3.8 weeks. The median time since admission for those patients on the end of year rolls has dropped during the last eight years from nearly 9.5 years to 4.3 years at the end of 1974.

Area D Community Mental Health Center

A major step in the conversion of Saint Elizabeths Hospital into a modern community-based mental health facility was the establishment of the Area D Community Mental Health Center (CMHC) in 1969. The CMHC serves approximately 170,000 residents of that southeast portion of the District of Columbia designated as Area D, and which has the massive social problems associated with urban localities. The Area CMHC now has on its rolls an average of about 1,500 patients, of which over 1,250 are outpatients. From its inception 9,124 patients have been admitted for treatment in the Center.

Collaborative Efforts

Saint Elizabeths continues to expand its participation in community activities, such as the vocational rehabilitation program which is operated jointly with the D.C. Bureau of Rehabilitation Services. During the past year, the Hospital made 337 referrals with 114 patients being successfully rehabilitated. The District also cooperates with the Hospital in the operation of a transitional workshop, which rehabilitated 54 of the 226 patients served during the year, and a Home Arts Center which rehabilitated 29 of the 185 patients served during the year.

Members of the professional staff, both officially and individually, provide consultative and educational services on request to D.C. community agencies and personnel. The Hospital also cooperates with local mental health associations in finding jobs for former patients.

Clinical Training and Research

The 1976 request includes $2,910,000 to support clinical training and research programs. In 1976, the Hospital will provide year-round training to students from local medical schools, and will support graduate and post-graduate programs in mental health such as those for internships and psychiatric residency education for physicians. In addition, training will be provided for other mental health professionals in the disciplines of dentistry, nursing, psychodrama, social service, clinical psychology, group training, chaplaincy, dance therapy and volunteer services. Special workshops on community mental health will be provided, and extensive training will be conducted for groups from the community served by the Hospital.

The goal of the Hospital's research activities is to better understand the causes of mental disorders and the factors bearing upon their development, treatment, and prevention. The research program is intimately linked to clinical care and training so as to maximize the benefits to the total program of the Hospital. Research studies in 1976 will be conducted in the areas of behavior analysis and therapy, criminal behavior, psychiatric nursing, hospital and community studies, and studies of families troubled by mental disorder or dysfunction.

Objectives for 1976

During 1976 the Hospital will proceed towards full unitization of services to patients.

Under the Unitization of the Hospital, the clinical services are being decentralized into smaller treatment units within which a basic unit will provide patient-centered treatment and continuity of care to an individual patient.

Continued efforts will be made to reduce the Hospital's inpatient load which, in turn, will relieve overcrowding. The Hospital also plans to make other improvements such as the strengthening of day care and night care services.

The requested increase of $4,682,000 includes $3,196,000 for built-in salary and wage grade pay increases, and $1,486,000 for cost of living increases in costs of supplies such as utilities, food for patients, and fuel oil for heating.

SAINT ELIZABETHS HOSPITAL

Program Purpose and Accomplishments

Activity: Clinical and Community Services

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
4,028	$47,670,000	Indefinite	4,023	$48,064,000

Purpose: Saint Elizabeths Hospital provides mental health treatment, care and rehabilitation services. The Hospital has operated a security treatment facility and a comprehensive mental health center which services District of Columbia residents in the southeast quadrant of the city. Saint Elizabeths also conducts a clinical research program and provides multidisciplinary clinical training for professional and related personnel.

Explanation: The Hospital operates with an indefinite appropriation, which fixes a total operating ceiling and provides that direct Federal appropriations will make up the difference between the total authorized ceiling and the amount of reimbursements received during the year. Virtually all reimbursements received are for inpatient care. The principal reimbursing agency is the District of Columbia.

Accomplishments in 1975: The Hospital continued further implementation of the unit plan with emphasis on the team approach in the treatment and care of patients. Admissions reached an all time high of 4,400; however, by providing more intensive early inpatient care and through continued emphasis on the early return of patients to productive community life, the Hospital was able to discharge a record high 4,100 patients and to achieve a slight reduction in the average daily patient load. Over 10,100 patients were treated, including an average of 2,850 outpatients. The narcotic addiction program is being expanded to serve approximately 75 patients. Intensive care units are being established in the Medical and Surgical Branch.

Objectives for 1976: To proceed with the conversion of the Hospital into a modern community oriented facility, including the unitization of services to patients. To offer comprehensive care and treatment services to all patients, including those requiring special care, within a catchment area. More community involvement will be emphasized with added participation by the staff in consultation activities with local health, welfare and other institutions. To promote better working relations with the catchment areas of the District of Columbia, especially in preventive psychiatry. Continued emphasis on the out-placement program with hope that unitization will enable further reduction in the inpatient population.

SAINT ELIZABETHS HOSPITAL

Reimbursement Detail

	1975 Estimate		
	Appropriation	With Supplem.	1976 Estimate
Reimbursements from Federal and Trust Funds:			
Veterans Administration	$27,000	$28,000	$30,000
U.S. Soldiers Home	49,000	51,000	55,000
Public Health Service (Indians)	52,000	54,000	58,000
U.S. Nationals	576,000	598,000	649,000
U.S. Prisoners	95,000	98,000	109,000
Soc. Sec. (Medicare payments)	300,000	300,000	300,000
General Services Administration	18,000	18,000	18,000
Subtotal	1,117,000	1,147,000	1,219,000
Payment received from Non-Federal sources:			
District of Columbia	21,592,000	21,592,000	25,808,000
Cafeteria sales	87,000	87,000	87,000
Sale of scrap	8,000	8,000	8,000
Subtotal	21,687,000	21,687,000	25,903,000
Total reimbursements	22,804,000	22,834,000	27,122,000
Per diem rate:			
District of Columbia	$24.53	$24.53	$29.80
Other	62.53	64.76	70.42

Statement of Average Daily Patient Population

	1974 Actual	1975 Estimate	1976 Estimate
Reimbursable			
Public Health Service (Indians)..	2	2	2
D.C. (Residents).....	1,653	1,635	1,600
D.C. (Vol. and Non-protesting)...	554	552	545
D.C. (Prisoners).....	238	235	230
D.C. (Jury Trial).....	24	23	20
U.S. Soldiers Home.....	2	2	2
Veterans Administration.....	1	1	1
U.S. Nationals.....	24	25	25
U.S. Prisoners.....	5	5	5
Reimbursable Totals.....	2,503	2,480	2,430
Nonreimbursable			
Military.....	64	60	60
D.C. Non-residents.....	218	214	214
Public Health Service.....	4	4	4
Virgin Islands.....	71	76	76
Other.....	20	16	16
Nonreimbursable Totals...	377	370	370
Total, Inpatients.....	2,880	2,850	2,800

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

Amounts Available for Obligation

	1976 Estimate	Interim Period
Appropriation	$48,064,000	$15,500,000
Receipts and reimbursements from:		
Federal funds	919,000	170,000
Trust funds	300,000	55,000
Non-Federal sources	25,903,000	4,775,000
Total, obligations	75,186,000	20,500,000

Obligation by Activity

	1976 Estimate	Interim Period*
Clinical and Community Services:		
Total obligations	$75,186,000	$20,500,000

* The interim budget is derived by calculating 25% of total estimated FY 77 obligations.

Obligations by Object

	1976 Estimate	Interim Period
Total number of permanent positions	4,028	4,028
Full-time equivalent of all other positions	134	134
Average number of all employees	4,105	4,105
Personnel compensation:		
Permanent positions	$50,680,000	$13,818,000
Positions other than permanent	1,621,000	442,000
Other personnel compensation	3,327,000	907,000
Special personal service payments	485,000	132,000
Total personnel compensation	56,113,000	15,299,000
Personnel benefits	5,175,000	1,411,000
Travel and transportation of persons	242,000	66,000
Transportation of things	86,000	24,000
Rent, communications and utilities	1,384,000	377,000
Printing and reproduction	56,000	15,000
Other services	2,124,000	579,000
Supplies and materials	8,494,000	2,316,000
Equipment	1,307,000	357,000
Lands and structure	227,000	61,000
Insurance claims and indemnities	4,000	1,000
Subtotal	75,212,000	20,506,000
Deduct charges for quarters	-26,000	-6,000
Total obligations by object	75,186,000	20,500,000

Justification

Saint Elizabeths Hospital

	1976 Estimate	Interim Period
Personnel compensation and benefits	$61,288,000	$16,710,000
Other Expenses	13,924,000	3,796,000
Deduct charges for quarters	-26,000	-6,000
Total	75,186,000	20,500,000

General Statement

This interim budget is for the operation (during the transition phase from FY 1976 to FY 1977) of the St. Elizabeths Hospital, which provides treatment and rehabilitation of the mentally ill and also operates a community mental health center for the District of Columbia residents in the southeast quadrant of the city. The hospital conducts a clinical research program for the purpose of obtaining a better understanding of the causes of mental disorders, and possible prevention, and a clinical training program for professional and ancillary personnel engaged in or interested in mental health activities.

During fiscal year 1974, over 10,000 patients were treated at Saint Elizabeths Hospital, with admissions reaching a high of 4,027 patients. Through intensive research and improved treatment methods, the hospital will continue its efforts to relieve the present situation of overcrowding. As this situation improves, efforts will be made to strengthen day care and night care services.

The interim budget is derived by calculating 25% of total estimated FY 77 obligations.

HEALTH RESOURCES ADMINISTRATION

WITNESSES

DR. KENNETH M. ENDICOTT, ADMINISTRATOR
DR. DANIEL F. WHITESIDE, DIRECTOR, BUREAU OF HEALTH RESOURCES DEVELOPMENT
DR. GERALD D. ROSENTHAL, DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH
DR. EDWARD B. PERRIN, DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS
JOHN P. BUCKLEY, ACTING DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER
DR. COLIN C. RORRIE, JR., DEPUTY DIRECTOR, DIVISION OF COMPREHENSIVE HEALTH PLANNING

Mr. FLOOD. We will now consider the budget for the Health Resources Administration. The presentation will be made by Dr. Kenneth M. Endicott, the Administrator, and while we know your biographical sketch by heart, we have to put it in the record anyhow, so we will do that.

[Dr. Endicott's biographical sketch follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Resources Administration

Biographical Sketch

NAME : Kenneth Milo Endicott, M.D.

POSITION : Assistant Surgeon General, Public Health Service
Administrator, Health Resources Administration

BIRTHPLACE AND DATE : Canon City, Colorado
June 6, 1916

EDUCATION : A.B., University of Colorado, Boulder, 1936
M.D., University of Colorado, Denver, 1939

EXPERIENCE :

Present	Administrator, Health Resources Administration
1969-1973	Director, Bureau of Health Manpower Education
1960-1969	Director, National Cancer Institute, National Institutes of Health, US Public Health Service, DHEW
1960	Appointed Assistant Surgeon General, U.S., P.H.S.
1958-1960	Associate Director, National Institutes of Health
1955-1958	Chief, Cancer Chemotherapy National Service Center, National Cancer Institute
1951-1955	Scientific Director, Division of Research Grants, National Institutes of Health
1942-1951	Chief, Section on Metabolic and Degenerative Diseases, Division of Pathology, National Institutes of Health
1942	Medical Center for Federal Prisoners, Springfield, Missouri
1941-1942	Maritime Quarantine Station, San Francisco, California
1940	U.S., PHS, Relief and Quarantine Station, Portland, Oregon
1940	Commissioned in U.S., PHS
1939	Intern, U.S. Marine Hospital, Seattle, Washington

ASSOCIATION MEMBERSHIPS :
Diplomate, American Board of Pathology
American Medical Association, Fellow
American Association for the Advancement of Science
American Association of Pathologists and Bacteriologists
Society for Experimental Biology
Society for Experimental Pathology
Alpha Omega Alpha
Phi Rho Sigma
Theta Xi

SPECIAL AWARDS :
Distinguished Service Medal of the Public Health Commissioned Corps, awarded 1964: "For his outstanding and distinguished leadership in Medical Research Administration and National Cancer Research Programs".
Doctor of Science (Honorary) - St. Norbert College, DePere, Wisc. 1967
First PAP Award for Distinguished Service by the Board of Director of the Papanicolaou Cancer Research Institute, Miami, Florida, January 9, 1970
Doctor of Science (Honorary) - University of Colorado, 1970
Doctor of Public Service (Honorary) - Temple University, Philadelphia, Pennsylvania, May 1972

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Resources Administration

Biographical Sketch

NAME : Daniel F. Whiteside, D.D.S.

POSITION : Director, Bureau of Health Resources Development

BIRTHPLACE AND DATE : Palatka, Florida
May 1, 1931

EDUCATION : Predental, University of Florida, 1949 to 1952
Doctor of Dental Surgery, University of Maryland, 1952 to 1956
Master of Public Health, University of North Carolina, 1960 to 1961

EXPERIENCE :

Present	Director, Bureau of Health Resources Development
1973-1975	Associate Administrator for Operations and Management Health Resources Administration
1971-1973	Associate Director, Bureau of Health Manpower Education
1970-1971	Director, Division of Grants and Contracts, BHME
1969-1970	Director, Division of Health Manpower Educational Services, Bureau of Health Professions Education and Manpower Training
1967-1969	Deputy Director, Division of Health Manpower Educational Services, Bureau of Health Professions Education and Manpower Training
1961-1966	Chief, Dental Auxiliary Utilization and Development Section, Division of Dental Health, Washington, D.C.
1960-1961	Training outside the Service
1958-1960	Chief, Dental Services, Pine Ridge Indian Hospital, Division of Indian Health, Pine Ridge, South Dakota
1957-1958	Staff Dental Officer, Sisseston Indian Hospital, Division of Indian Health Sisseston, South Dakota

ASSOCIATION MEMBERSHIPS : Diplomate, American Board of Dental Public Health
Fellow, American Public Health Association
American Association of Public Health Dentists
American Dental Association
Delta Omega
Gorgas Odontological Society

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Resources Administration

Biographical Sketch

NAME : Gerald Rosenthal, Ph.D

POSITION : Director, Bureau of Health Services Research, HRA

BIRTHPLACE AND DATE : Reading, Pennsylvania
January 2, 1934

EDUCATION :
A.B., Cornell University - Economics, 1958
S.M., Cornell University - Labor Economics & Statistics, 1959
Ph.D., Harvard University- Economics, 1963

EXPERIENCE :

Present	Director, Bureau of Health Services Research, HRA
	Consultant, Cost of Living Council, Office of Wage Stabilization
	Associate Professor, Brandeis University, Department of Economics and Florence Heller Graduate School of Social Welfare
1973-1974	Public Member and Chairman, Health Industry Wage & Salary Committee, Cost of Living Council
1972-1973	Member, Advisory Committee, Study of Mental Hospitals in Massachusetts, DMH and United Community Services
1972-1973	Member, Task Force on Financing of Mental Health Services, NIMH
1972-1974	Member, Committee to Study Inborn Errors of Metabolism, National Academy of Science, Division of Medical Science
1972-1973	President, Massachusetts Public Health Association (Vice President 1971-72; Chmn, Legislative Committee 1966-67)
1970	Member, Planning Committee, National Health Forum
1969	Member, Task Force on Health, National Urban Coalition
1969	Member, Task Force on Health Facilities, Office of Comprehensive Health Planning, Commonwealth of Massachusetts
1969-1970	Member, Subcommittee on Cost & Cost Analysis, National Conference on Automated Multiphasic Health Testing, National Center for Health Services Research and Demonstration
1968-1971	Member, Comprehensive Health Planning Training Review Committee
1968-1970	Member, Committee on Health Services Research, Medical Care Section, American Public Health Association
1967	Member, Ad Hoc Committee on Medical Care Facilities, USPHS
1966-1967	Member, Renal Disease Study Committee, Bureau of the Budget

PUBLICATIONS:
State Financing of Mental Health Services, prepared for Task Force on Financing, NIMH, 1973
The Economics of Human Services, Behavioral Press (Forthcoming, 1974)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Resources Administration

Biographical Sketch

NAME : Edward B. Perrin, Ph.D.

POSITION : Director, National Center for Health Statistics
Health Resources Administration

BIRTHPLACE AND DATE : Greensboro, Vermont
September 19, 1931

EDUCATION :
B.A., Middlebury College, (Vt.), Mathematics (cum laude), 1949-1953
Edinburgh University (Scotland), Mathematics, 1953-1954
M.A., Columbia University, Math Statistics, 1954-1956
Ph.D., Stanford University, Statistics, 1956-1960

EXPERIENCE :

Present	Director, National Center for Health Statistics Health Resources Administration
1972-1973	Deputy Director, National Center for Health Statistics
1970-1972	Professor and Chairman, Department of Biostatistics, Schools of Public Health and Community Medicine, University of Washington
1962-1970	Assistant Professor, Associate Professor and Professor, Department of Preventive Medicine, School of Medicine, University of Washington
1959-1962	Assistant Professor, Department of Biostatistics, Graduate School of Public Health, University of Pittsburgh

HONORS (partial list) : Phi Beta Kappa, Milbank Faculty Fellow (1964-1969)
Spiegelman Gold Medal (1970)

UNIVERSITY COMMITTEES (partial list) :
Committee for Curricular Coordination (Chairman, Medical Scientist Pathway), School of Medicine, University of Washington, 1967-1970
Member, Admissions Committee, School of Medicine, University of Washington, 1968-1970
Member, Faculty Senate, University of Washington, 1969-1971
Chairman, Biomathematics Group, Graduate School, University of Washington, 1969-1972

NATIONAL ADVISORY COMMITTEES (partial list) :
Biometrician, V.A. Cooperative Study on Treatment of Esophageal Varices, 1961-Present
Senior Consultant - Biostatistics, Washington - Alaska Regional Medical Programs, 1967-1971
Member, Epidemiology and Disease Control Study Section, Division of Research Grants, NIH, 1969-1973

SOCIETIES (partial list) :
American Statistical Association, Fellow 1972
Biometric Society (Past President, WNAR)
American Association for Advancement of Science, Fellow, 1965
American Public Health Association, Fellow, 1964
Institute of Mathematical Statistics
International Union for the Scientific Study of Population

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Resources Administration

Biographical Sketch

NAME : Colin Campbell Rorrie, Jr.

POSITION : Deputy Director, Division of Comprehensive Health Planning

BIRTHPLACE AND DATE : Chicago, Illinois
March 9, 1942

EDUCATION :
Ph.D., University of Iowa - Hospital and Health Administration, 1968
M.A., University of Iowa - Hospital and Health Administration, 1966
B.A., Beloit College - History, 1964

EXPERIENCE :

Present	Deputy Director, Division of Comprehensive Health Planning, HRA
1972-1973	Director, Division of Resource Development and Assistance, Comprehensive Health Planning Service, HSMHA
1971-1972	Special Assistant to the Director, CHPS, HSMHA
1969-1971	Director of Continuing Education and Instructor in Hospital Administration, Washington University School of Medicine
1968-1969	Assistant to Executive Director, American College of Physicians
1967-1968	Teaching Assistant, University of Iowa
1964-1965	Administrative Assistant to the Administrator, Illinois Masonic Medical Center

ASSOCIATION MEMBERSHIP : American Hospital Association
American Public Health Association
American College of Hospital Administrators
Association of American Medical Colleges

AWARDS AND SCHOLARSHIPS : Public Health Service Traineeship
1965-1968

Mr. FLOOD. Do you have some people with you that you want us to know?

Dr. ENDICOTT. To my far left is Dr. Daniel Whiteside, the new Director of the Bureau of Health Resources Development. Then we have Dr. Gerald Rosenthal, Director of the National Center for Health Services Research; Dr. Edward Perrin, Director of the National Center for Health Statistics, and Dr. Colin C. Rorrie, Deputy Director, Division of Comprehensive Health Planning.

Mr. FLOOD. You have a prepared statement. How do you want to handle this?

Dr. ENDICOTT. I would prefer to read it, if I may.

Mr. FLOOD. It is up to you.

1976 OVERVIEW

Dr. ENDICOTT. Mr. Chairman and members of the committee, we are here today to testify in support of the 1976 budget for the Health Resources Administration. We are requesting $611,487,000 for all programs including manpower. We are also requesting $135,290,000 for the 3-month interim period between fiscal years 1976 and 1977.

In coming before you to present the budget request for the programs of the Health Resources Administration I am struck with the fact for the first time in the Health Resources Administration's history we have the possibility of a solid budget year.

Mr. FLOOD. I didn't understand that sentence.

Dr. ENDICOTT. Well, last year, sir, as you will recall, all of our legislation had expired, so there was no occasion to appear at all. This year about two-thirds of it has been enacted, so we are having an appropriation hearing on that portion I am hoping that next year we will have a normal budget year.

Since this organization was formed in July 1973, we have administered our programs of health services research, data collection, planning, and manpower with fragmented budgets and expired authorizations.

This year, I hope, will be different.

At the time the Health Resources Administration was established in July 1973, virtually all of its authorizing legislation had expired.

Subsequently, parts of our authorizations were enacted piecemeal. Legislation was enacted in 1974 for the continuation of student assistance and in the important fields of health services research and health statistics and early in 1975 for the consolidation of our health planning activities. The largest item in our budget, health manpower, remains unresolved, and we are still operting the health manpower authorities through continuing resolutions.

We now are faced with important jobs to do which we hope will lead to some significant improvement in the way we will deliver health care in this country. Much of the activity, especially in health statistics, health services research, and health planning is being carried out in preparation for national health insurance. We must come up with answers to some very difficult problems—how to restrain the rise in costs, how to assure quality, how to measure the health status of the American people, and how does that status relate to the way our health resources are used.

Our requests for both the National Center for Health Statistics and for the National Center for Health Services Research are modest, and I would urge that these amounts be granted so that we can strengthen our local, regional, and national data gathering and health services research, and be ready to answer the many questions the public and the Congress have a need and a right to ask.

DEVELOPMENT OF KNOWLEDGE

Along with the other agencies in the Public Health Service, we in HRA are concerned with the development of knowledge useful for the delivery of better health care. The National Center for Health Services Research—authorized in the Health Services Research, Health Statistics and Medical Libraries Act of 1974—has focused its research activities upon the most relevant issues in health services: rising costs and productivity, health manpower, emergency medical services, health care and the disadvantaged, health insurance plans, quality of care, and methods of planning and regulation.

This Research Center will carry out its research through extramural grants and contracts as well as through a new intramural research capacity. Establishing research competence in-house is a new and difficult task. Nevertheless, we are reexamining our priorities, using our personnel in different ways, and by trying to attract first class research talent to spend some time at the National Center to work on priority projects.

Another new program of support, which we have just announced, will fund at least six health services research centers. These centers will be located at existing universities or research centers and will deal with the full range of health services research problems. Each center will put extra effort into those problems that are of major significance to its region. In addition, one center will be designated as the Health Care Technology Center.

Mr. FLOOD. Of course, you will list those for the record, if you don't have them there?

Dr. ENDICOTT. We will be able to next year. We are still in the process of selection, sir.

Mr. FLOOD. All right. What do you mean next year, next fiscal year?

Dr. ENDICOTT. The competition will be carried out in the first quarter of the next fiscal year.

Mr. FLOOD. So by the end of the calendar year we should know?

Dr. ENDICOTT. Probably by the first of September.

Mr. FLOOD. That soon?

Dr. ENDICOTT. The other was the Health Care Management Center. We expect to announce these particular awards in late summer.

Mr. FLOOD. You don't want to whisper to me right now what they are?

Dr. ENDICOTT. I would, but Dr. Rosenthal won't tell me.

Mr. FLOOD. Oh, all right; fair enough.

Dr. ENDICOTT. Elsewhere in the Agency, using the authorities of the National Health Planning and Resources Development Act of 1974, we are establishing a National Health Planning Information Center to make it easier for people to get the best and latest information available on health planning. We will also support the development of

the best methods and techniques for health planning and will provide technical assistance to help State and local agencies evaluate and use new planning methods.

Our Office of Health Resources Opportunity will continue to generate more information about improving health services for the disadvantaged and will develop more effective ways of telling highly motivated, skilled, but disadvantaged young people about significant health careers and attracting them into training for these careers.

IMPROVEMENT OF HEALTH CARE SYSTEMS

One of our major priorities within the Health Resources Administration is to see how we can improve the Nation's health care systems. The major vehicle we have to do this will be through the development of a nationwide network of local health systems agencies. Together with State Health Planning Resources Development Agencies and Statewide Health Coordinating Council, which will advise them, these agencies will plan for the health needs of their communities and review requests for Federal funds for new health facilities or services.

Prior to the full establishment and funding of the new agencies, we must make provision for the existing comprehensive health planning, regional medical program, and experimental health service delivery systems agencies. As you know, I appeared before you a few weeks ago seeking authority and funds for just such a transition. Even now, we are reviewing applications of existing agencies in anticipation of funding in the fourth quarter of this fiscal year.

I am here today requesting, for the first time, funds to support the establishment of the new agencies in fiscal year 1976. Our request is based on our objective to provide an orderly phaseout of the old and a rational phasein of the new.

After the State Governors designate their health service areas, which should be by August 1, 1975, we will review the applications of the prospective health systems agencies and begin to fund their operations. We hope that health planning for these areas of between 500,000 and 3 million people, as the law requires, will help make them more manageable and effective for health planning and health delivery.

MANAGING THE HEALTH CARE DELIVERY SYSTEM

Parenthetically, I would like to mention that I think what we are about in this program is, in a reasonably gentle fashion, imposing a system of management on the private enterprise delivery of personal health services. This will be the nearest thing we have had so far to some kind of a nationwide system of management in what is basically a private enterprise.

Mr. FLOOD. You are not talking about the gubernatorial designation of the districts; are you?

Dr. ENDICOTT. No; I am talking about the total system when it is in operation. It is sort of an experiment, I think, in management of private enterprise. We are encountering less political opposition and difficulties than I had initially expected, and I think that this is an experiment in government that we all ought to watch closely.

Mr. FLOOD. That is not true, however, of the authority of the Governors to designate the statistical census areas as the locality, because you stir up a can of worms. That is a nightmare, that one, all of a sudden. The Governors now are designating the census district, you know what I mean, and they have now crossed the lines. Many existing and first-class operations are already set up and now this new order coming from the separate Governors saying no matter how good you are or what counties were in the district before this, now this is the new one. Haven't you heard about this?

Dr. ENDICOTT. Yes, sir, that is prescribed in the statute.

Mr. FLOOD. I know that.

Dr. ENDICOTT. I didn't prescribe that part of the experiment. But that is one which is attracting some attention; yes, sir.

Mr. FLOOD. But that headache is the Governors'; isn't it?

Dr. ENDICOTT. Yes, sir, and we are happy to delegate that one.

Mr. FLOOD. All right.

Dr. ENDICOTT. We expect to fund approximately 200 health systems agencies during fiscal year 1976. When the agencies are designated, the level of Federal support will increase, and the agencies will be ready for full operation.

The State health planning and resource development agencies which should be designated and funded by January 1, 1976, will continue the planning functions of State comprehensive health planning agencies, perform the capital expenditure reviews under the Social Security Act, and administer the health facilities construction grants formerly performed by the Hill-Burton State agencies. In addition, these new State agencies will provide staff support to the statewide health coordinating council, coordinate the implementation of the State health plan—which includes planning for facilities construction—administer State certificate of need programs and review all institutional health services at least once every 5 years to determine their continued appropriateness. That last function is kind of a sleeper because, in effect, this charges the agencies with reviewing all the services offered in the State other than those offered by individuals. Although the sanctions are not clear, it is the implied sanction of the withholding of Federal funding, I think, which makes this review an extremely important function and one which I hope will receive serious consideration on the part of these agencies, because it does offer an opportunity for a great deal of needed housecleaning.

The capital expenditure reviews have been one of the most successful activities among State and local agencies. Through this review in its first year we prevented an estimated $200 million in Federal support from being channeled into unnecessary construction and equipment.

We are not requesting support for area resources development funds in fiscal year 1976 since we do not anticipate that the health systems agencies will be far enough along to be eligible for that money. And here I would like to draw attention to the fact that the development funds here referred to are the nearest thing in the new legislation to the successor of the old RMP program. The one thing which is missing to make it a true successor is an authorization for the support of the core staff of the RMP's. I know there have been many discussions in the Congress with regard to the ultimate fate of the RMP projects, and there is money both in the continuing resolution and the second

supplemental budget for RMP projects. It must be realized too, that this next fiscal year is a transition year, because the new planning system will not be ready to cope with developmental funds until near the end of fiscal 1976, when RMP will be sort of gasping its last at that time. That would appear to me personally at least to be the appropriate time to phase in the developmental activities.

We are currently carrying out an intensive in-house review of all ongoing RMP projects to try to assure that the really worthy ones do not fall between the cracks.

Mr. FLOOD. And there are some really worthy ones.

Dr. ENDICOTT. Yes, sir, there are. Knowing of your personal interest in RMP, I wanted to offer that comment.

Mr. FLOOD. Yes.

HEALTH FACILITIES CONSTRUCTION ASSISTANCE

Dr. ENDICOTT. Funds available for health facilities construction will be limited to modernization of outdated facilities, construction of outpatient facilities and conversion of existing facilities to provide new services. Construction of new inpatient facilities will be confined to areas of dense and rapid population growth. Grants amounting to 22 percent of the construction funds available to the States will be made directly to publicly owned facilities for projects to eliminate safety hazards or to assure compliance with State licensure or accreditation standards. It is a pity St. Elizabeth's isn't eligible here.

One major element of our work in improving our health-care systems in this country is still not in place. Legislation authorizing health manpower programs is being developed by the Congress. We do not know what the specifics of such legislation will be. But we do know the major issues and problems that must be attacked in such legislation.

We still need to improve the geographic and specialty distribution of health services and the people who deliver these services. We need greater numbers of primary-care physicians. We had been supporting schools simply to increase the numbers of graduates. Now we will shift support to feature incentives to attract students who will practice in shortage areas after getting the training for it.

Our projections of health manpower supply indicate that by 1985 we will increase the number of physicians by more than 50 percent and dentists by 40 percent. In nursing, also assuming maintenance of our current and planned training capacity, we anticipate an increase of 74 percent of registered nurses from 1970 to 1985.

So, rather than concentrate merely on expensive numerical growth alone, we are proposing: (1) continued, though phased-down capitation support to health professions schools; (2) startup support for those schools which have required such support in the past; and (3) assistance to schoools in financial distress. This program will permit present levels to be maintained and, at the same time, help us strengthen our programs to improve distribution.

The financial help we will extend to students should have incentives to encourage graduates to go into underserved areas and into careers which are projected to be undermanned.

More than 400 health professions graduates have used the loan repayment provisions, permitting them to repay up to 85 percent of their education loans by practicing in underserved areas.

This past February, we notified 850 medical and osteopathic students nearing graduation that they had been selected to receive public health scholarships requiring some period of service in a needed area. We expect to award an additional 1,000 of these scholarships by the end of this fiscal year. The excellent response to such programs shows that many students are willing to accept financial assistance tied to a commitment to serve in these problem areas. We expect to support about 2,300 public health and national health service corps scholarships in fiscal year 1976.

PREVENTION

If we are to help prevent illness and help erase the human and economic costs of illness, we need more primary-care practitioners. Right now we are encouraging more practitioners to enter these fields. Of the 3,500 family medicine residencies now offered in this country, 1,500 are federally supported. Our proposal would expand the Nation's total to 4,850 residencies of which 3,000 would be federally supported. We are also expanding our support to train nurse practitioners, physician assistants, and dental therapists.

In addition, projects, such as those conducted by area health education centers, provide clinical training in underserved geographic areas for a variety of health, allied health, and nursing professionals. These projects, in 11 areas, encourage students to enter primary-care practice and strengthen health care provided in those underserved areas. Approximately 15,000 students will receive a portion of their undergraduate, graduate, and short-term nondegree training in hospital and ambulatory care settings offered by these centers during fiscal year 1976. Our support of a program at the University of Washington has and will continue to help train physicians for practice in remote areas of Washington, Alaska, Montana, and Idaho.

Our Office of Health Resources Opportunity will provide funds for projects to attract motivated young people into training for careers in underserved fields and areas.

These programs and other like them have begun to make some impact on our ability to attract qualified and motivated professionals into areas of need.

QUALITY ASSURANCE

Even if we develop quality systems for delivering health care and quality systems for producing health personnel to deliver this care, we still must be sure that the care the American people receive is of a high quality. Our manpower programs have already helped develop proficiency examination for physician assistants and are developing such examinations for such groups as occupational therapists, medical record personnel, and radiologic technologists. We are examining the difficult problems of maintaining competency among health professionals. We are providing training funds to help the health professionals work effectively with auxiliaries.

Our National Center for Health Service Research is taking a careful look at what means can be used to assess the quality of care. We need better, more reliable, and more objective methods for assessing and measuring quality of care. We have to find out what the relationship is between any particular course of treatment and the outcome we expect. Parallel to this, we are looking into ways to improve the

quality of care by applying the systems technology now within our grasp, such as how we can better use computers to make diagnoses that are beyond the ability of individual professionals. The National Center currently is engaged in projects to find the answers. The problem-oriented medical record, treatment protocols for physician extenders, and a computer-based system for identifying the potential for harmful drug interactions are just three examples of the investigations now supported by the National Center for Health Services Research.

Poor quality of care and our inability to assess quality are being translated into patient demands for financial redress for errors in treatment. The National Center intends to look at the probability of reducing the number of malpractice claims through such mechanisms as medical arbitration, and informed consent.

TRACKING AND EVALUATION

Our program of health data gives us an overview of the state of health of the American people, the numbers and types of health resources, and the way these health resources are used. This information provides the base on which we evaluate our health programs and policies—how, or instance, programs of improved financial access and biomedical research affects the health of the American people.

In the past, the health statistics program has provided national-level data about a range of health conditions. Now, with the recent and planned expansion of programs to improve the planning for and quality of health care, and especially with the movement toward a national health insurance, we need more specific data on the State and local levels.

For example, the National Health Planning and Resources Development Act of 1974 requires the analysis of data that not now available. This is also true of the data needed by the professional standards review organizations.

To meet these and other data needs, the National Center for Health Statistics has developed and begun to put into practice a cooperative health statistics system. This system should satisfy the data need of users at all Government and private levels; it will collect the data only once at whatever level is most economical and feasible; and it will share the data with all users at all levels. This way, we will get comparable data for our various programs in the most economical way.

The States have been enthusiastic in accepting this system and so far we have 23 States providing us with vital statistics, 9 States with manpower data, and 5 States with facilities data. The States accept this system. If our full budget request is granted, we can increase our support of State data collection systems in 1976 and have 35 States providing vital statistics, 15 States providing manpower data, 12 providing facilities data, and 5 providing hospital care data. Our goal is to establish a data network which will be of use in all States and health planning areas by providing data for local, State, and Federal use.

I would like to emphasize that if we don't expand this cooperative approach soon, we will end up with a conglomeration of costly, unrelated, and less efficient data systems. It is far better to work for one economical system that can be used to meet our needs now and into the future.

I will now be glad to answer any questions you may have.

OPERATING UNDER CONTINUING RESOLUTION

Mr. FLOOD. Doctor, you have a large segment of all your programs, as you indicated, that have been operating under a continuing resolution. That is due to the absence of any authorizing legislation.

What sort of problems have you encountered as a result of operating under a continuing resolution?

Dr. ENDICOTT. Probably our most difficult decision was that of deciding whether to hold a round of competition for awards under the old health manpower legislation or wait for the enactment of new authorities. Based on assurances which I had from the subcommittee chairman, I postponed that decision until the adjournment of the last Congress. At that point, about January 1, it seemed reasonable to assume that legislation would not be enacted retroactively effective for this fiscal year, so we initiated a grant review cycle.

In effect, this compressed the whole process of reviewing awards into 6 months.

Mr. FLOOD. Have you been able to meet all of the grant and contract commitments under the continuing resolution?

Dr. ENDICOTT. I believe that we will, sir. The nature of the continuing resolution is such that for those budget activities for which no lands were requested in the 1975 President's budget, the amount available is the amount in last year's appropriation.

The 1974 appropriation was, as you will recall, substantially above the President's budget, and as far as I can tell in most areas we will be able to meet our commitments.

Mr. FLOOD. Let me ask you this. Will you be able to initiate any new grants or contracts or loans under the continuing resolution?

Dr. ENDICOTT. Yes, sir, we will. Now I understand that a request for rescission has been submitted, in which case in some limited areas that would not be true.

Mr. FLOOD. We should have hearings on the proposed rescissions next week if we can. It will probably be midnight or something, but we will have to.

How much of the $611,487,000 in this budget lacks authorization legislation?

Dr. ENDICOTT. $342 million.

Mr. FLOOD. All right; I tell you what you do. At this point in the record, right here at this point, submit two tables. You can guess what they are. In one, list all of the programs in the budget that lack legislation. In the second table list all of the programs for which you have authorizing legislation and show the amount requested in each one of these programs.

Dr. ENDICOTT. Yes, sir.

[The information follows:]

HEALTH RESOURCES ADMINISTRATION

Programs Which Have Authorizing Legislation

Legislation	1976 Authorized	1976 Appropriation Requested
National Health Planning and Resources Development Act of 1974:		
Section 5 -- Miscellaneous and Transitional Provisions	Such sums as necessary	---
Public Health Service Act:		
Section 301 -- Research Grants and Contracts	Indefinite	$ 2,142,000
Section 308 (1) (1) -- National Center for Health Services Research	$80,000,000	26,000,000
Section 308 (1) (2) -- Health Statistics	30,000,000	25,636,000
Section 729 -- Loan Guarantees & Interest Subsidies	Indefinite	2,000,000
Section 741 -- Loan Repayment & Forgiveness	Indefinite	6,000,000
Section 742 -- Health Professions Student Loans	Such sums as necessary	20,000,000
Section 780 -- Scholarships Grants to Schools of Medicine, Osteopathy Dentistry, Optometry, Podiatry, Pharmacy, or Veterinary Medicine	Such sums as necessary	3,500,000
Section 809 -- Loan Guarantees and Interest Subsidies for Construction of Schools of Nursing	Indefinite	1,000,000
Section 823, 830 -- Loan Repayment and Forgiveness	Indefinite	2,500,000
Section 824 -- Nursing Student Loans	Such sums as necessary	9,000,000
Section 860 -- Scholarships Grants to Schools of Nursing	Such sums as necessary	4,000,000

(cont. pg. 2 - Programs Which Have Authorizing Legislation)

Legislation	1976 Authorized	1976 Appropriation Requested
Section 1514 -- Assistance to Entities Desiring to be Designated as Health Systems Agencies	Indefinite	200,000
Section 1516 -- Planning Grants	$90,000,000	$45,000,000
Section 1525 -- Grants for State Health Planning and Development	30,000,000	9,500,000
Section 1526 -- Grants to State Agencies for Rate Regulation	5,000,000	---
Section 1533 -- Technical Assistance for Health Systems Agencies for State Health Planning and Development Agencies	Indefinite	7,000,000
Section 1534 -- Center for Health Planning	8,000,000	
Section 1613 -- Grants for Construction for modernization of medical facilities	130,000,000	100,000,000
Section 1635 -- Technical Assistance	Indefinite	300,000
Section 1640 -- Development Grants for Area Health Services Development Funds	75,000,000	---
Social Security Act:		
Section 1122 -- Limitations on Federal Participation for Capital Expenditures	Indefinite	4,000,000
Program Management - PHS Act, Section 225, Titles III, VII, VIII, and XVI, and Social Security Act, section 1122	Inherently authorized	51,851,000

HEALTH RESOURCES ADMINISTRATION

Programs Which Lack Authorizing Legislation

Legislation

Public Health Service Act:

Section 225 -- Public Health and National Health Service Corps Scholarship Training Program

Section 306 -- Traineeships for Professional Public Health Personnel

Section 313 -- Project Grants for Graduate Training in Public Health

Section 767 -- Grants for Training, Traineeships, and Fellowships in Family Medicine

Section 770 -- Capitation Grants

Section 771 -- Start-up Assistance

Section 772 -- Special Project Grants and Contracts

Section 773 -- Financial Distress Grants

Section 774 -- Health Manpower Education Initiative Awards

Section 789 -- Physician Shortage Area Scholarships

Section 793 -- Traineeships for Allied Health Personnel

Section 794A -- Grants to Encourage Full Utilization of Educational Talent for Allied Health

Section 806 -- Nursing Capitation Grants

Section 808 -- Special Projects Grants and Contracts

Section 808 -- Nursing Financial Distress to Schools of Nursing

Section 810 -- Start-up Grants for New Nurse Training Programs

Section 821 -- Nursing Traineeships

Section 868 -- Grants to Encourage Full Utilization of Education Talent for the Nursing Professions

The Primary care residency program has been proposed for initial authorization in 1975.

MEDICAL MANPOWER SUPPLY AND DEMAND

Mr. FLOOD. In your opening statement you said by 1985 we will increase the number of physicians by more than 50 percent and dentists by more than 40 percent.

Now, you gave me the supply side of the equation; let me ask you to mention something about the demand side of the same equation. How many physicians and how many dentists will we need in 1985 if we have a national health insurance program in the next 2 years?

Dr. ENDICOTT. I think that our supply will be very close to what we need. Our projections anticipated the enactment of national health insurance and at the time the projections were made, there were a number of bills in the hopper, and we ran projections based on the most generous and the least generous of these and so far as we could tell we would be close to being in balance in 1985.

Mr. FLOOD. But you also said that you are encouraging more practitioners to enter the field of primary care. How are you doing this?

Dr. ENDICOTT. There are several mechanisms which appear to be effective. One is subsidy of family medicine, family practice residencies, and I believe our policy for the next few years should be saturation financing of the family medicine residencies.

Mr. FLOOD. You are on a continuing resolution now, no law; I am just wondering how you are going to do this.

Dr. ENDICOTT. Well, in this area I have no qualms whatever in moving aggressively. The residency program in family medicine is authorized under section 767 of the Public Health Service Act, and we have had full support from the Congress in this area. I have asked my staff to make sure that we fully fund in this area even though it means reprograming from other funds.

It has been a long, uphill pull to get the young doctors interested in this area, and now that they are beginning to apply for the residencies, I don't want to hold back.

Mr. FLOOD. You certainly will be facing a friendly court, so to speak. You have every reason to believe that.

Dr. ENDICOTT. The other principal tool, I think, addresses both the question of primary care and geographic distribution and that is the national health service corps, and, as you know, we have gone from a fellowship level of 3 million last year to 22.5 million this year. We have good applicants for the fellowships. We have many more sites requesting assignment of personnel than we can satisfy, so I think that these two mechanisms, coupled with a loan repayment program authorized in the Health Manpower Act of 1971 represent our best devices for getting people into primary care and into the community where they are needed.

HEALTH SERVICES RESEARCH

Mr. FLOOD. In your justification for the health service research, you say 18 jobs are assigned to this activity. Is this the total number of people that you have working in that?

Dr. ENDICOTT. No; in health services research, the 18 positions are assigned to intramural research.

Perhaps Dr. Rosenthal would like to comment.

Dr. ROSENTHAL. Most of the positions in the National Center are part of the HRA program management activity. The 18 positions in the intramural research program are funded out of the Health Services Research activity and thus show up as separately funded.

INTRAMURAL RESEARCH ACTIVITIES

Mr. FLOOD. On page 133 of your justifications you state that the Department has submitted to the Congress a proposal to repeal the requirement that 25 percent of the appropriations for the health service research be invested in direct research activity.

What is the status of your proposal anyhow? You made a proposal. Where is it? Do you know?

Dr. ENDICOTT. I don't know what the final decision has been in the Department.

Mr. FLOOD. All right. You can find that out and put it in the record. You may as well put it in the record at this point.

[The information follows:]

Public Law 93-353, approved July 23, 1974, extended and amended the authority to conduct health services research and for the conduct of various Federal health statistical activities. As a part of this extenison and amendment the Public Law requires that no less than 25 percent of the amount appropriated for health services research be available exclusively for services research, evaluation and demonstration activities directly undertaken by the Secretary. For several reasons the administration felt that this requirement was not appropriate and, accordingly, about 2 months ago submitted an amendment to the House and Senate committees of jurisdiction requesting that the 25 percent requirement be repealed in its entirety. No action has been taken on this repealing amendment and there is little reason to believe that any action will be taken on this amendment.

Mr. FLOOD. Why are you requesting repeal of this provision? Is this a bad idea or simply that you can't obtain the necessary employment ceiling in order to comply with the law? What is the matter?

Dr. ENDICOTT. Well, in part we were motivated to request a change in the language because the act came well along in the fiscal year, and it would have been in our view impossible to build up the staff during the first year, this current year. Now the other problem, put quite simply, is that increasing the Federal staff is quite contrary to administration policy, so the administration simply, I believe, just does not want to go ahead with building up the staff adequate to utilize 25 percent. Perhaps Mr. Miller can amplify it, but that is my reading.

Mr. FLOOD. How are you going to improve on that?

Mr. MILLER. My understanding has been, and I believe Dr. Endicott referred to it, and he may want to discuss it further, Congress, when they put that 25 percent provision in, simply imposed it upon an existing situation where the program was not currently spending anything like 25 percent, and it would have been very difficult to increase even without the administration's restriction on personnel, to that level.

In fact, there are letters before you now to reprogram funds for pay costs and other purposes which are based on the assumption that we are going to have to lapse money in 1975 because of that provision, not because we are holding the money back, but we can't spend it.

Mr. FLOOD. When you testified in September, you also told us you need about 150 jobs in order to undertake the intramural research effort. Is there still a good number, round, fat number, 150?

Dr. ENDICOTT. Yes, sir; based on the average cost and the amount of money involved, that is about the proper number.

Mr. FLOOD. Do you think you could comply with the requirement of the law, say if we were to give you a 3-or 4-year period over which to build up this intramural research activity?

Dr. ENDICOTT. Well, there are two things required.

Mr. FLOOD. That is a leading question?

Dr. ENDICOTT. Yes, sir. We could do it, but we need an increase in the authorized position ceilings.

Mr. MILLER. Mr. Chairman, I have to get back into this, too. Actually we requested an increase of 20 positions for this function last year in our budget request and the Congress rejected it.

Mr. FLOOD. Spread over a 3- or 4-year period, I meant.

Mr. MILLER. Those 20 positions were in our fiscal year 1975 request.

Mr. FLOOD. In the 1975 request?

Mr. MILLER. Yes.

Mr. FLOOD. By the way, how much are you currently investing in the business of intramural research right now, and how much for 1976?

Dr. ROSENTHAL. We think we will spend roughly $1 million this year, in fiscal year 1975, and we are trying to raise it by close to $3 million for 1976 to a total of $3.9 million.

SELECTING AREAS FOR HEALTH SERVICES RESEARCH

Mr. FLOOD. How do you identify the areas—now I am talking about health care delivery—how do you identify the areas in the health care delivery system that are going to be researched in any given year? How do you do that, with mirrors, or what?

Dr. ENDICOTT. Dr. Rosenthal has developed a very substantial effort to do this in an orderly way.

Dr. ROSENTHAL. We have structured a process that starts from the issues which we identify as important from legislation or from meetings with providers and users of services, and policymakers in the health area. We then bring together a group of individuals within and outside the Government to ascertain the degree to which there is research that you can do that will make a difference. We then design a research effort based on that advice. We try to program a few important areas rather than spreading our resources too thinly. Health manpower, insurance and financing, inflation and productivity, and health services to the disadvantaged are among those issues identified as important and in which the national center is undertaking research.

Mr. FLOOD. You know the argument we get here, not this committee, but this business about research. There are some people against research or any more research.

How do the results of your research find their way into the delivery system?

Dr. ROSENTHAL. There are four ways. In some ways it is easier for the health service researcher. First, a lot of our research takes place in service delivery settings. As we learn, we follow that right into changes

in the way services are provided. We also try to bring together people in a similar business, providing the same kinds of services, to share that experience. That is one informal way.

Second, we have begun targeting our publications, not waiting until they appear in some researcher's bulletin. Rather, we send information, either formally or informally, we know is of interest to people who need the results.

Third, we try to tell people early in the game what we are interested in doing. That way, people who want the answers, rather than those who want to do the research, come in contact with the center and are directly plugged in somehow to the research process.

Fourth, in our normal interaction with other health programs in the department, we make direct inputs into operational activity.

Mr. FLOOD. That point is important for the trouble we get into on on the floor. There is no question we do have ivory tower boys who want to research. That is why your third point is important.

You may want to develop this for the record, but can you give us a couple of examples of how this work you are talking about now in the health service research is going to improve access to care; is going to contain medical cost we hear about? Is it going to improve productivity?

EXAMPLES OF HEALTH SERVICES RESEARCH

Dr. ROSENTHAL. Let me take perhaps two examples that might be most productive. One is that we are now faced in the short run with a circumstance where municipal facilities particularly are undergoing a tremendous budgetary squeeze. There is a great problem with the financing of municipal facilities. They work in balanced budget settings and the budgets are being cut because of reductions in revenue. At the same time, we have some evidence that new individuals are coming to these facilities as a result of high unemployment rates and the cessation of insurance, that new individuals are showing up at these facilities, expanding the demand for them at the same time they are in a financial crunch.

We don't know that is true, but we suspect it. We have solicited research specifically targeted at that issue because we believe it is relevant for many other policies now underway.

Mr. FLOOD. Please expand that response for the record.

[The information follows:]

HEALTH SERVICES RESEARCH

The need to improve the knowledge of the health care delivery system is evidenced by the recent history of rising prices and increasing demand for services, of dissatisfaction with the accessibility, availability and quality of care, of new public policy initiatives, and of an overall economic setting which is beset with both inflation and unemployment. The need to moderate costs and increase access to productive and effective health services becomes clearer every day. It is to these ends to which the National Center for Health Services Research is committed.

Several examples of research projects and the implications of their funding are listed below.

1. ON-LINE MEDICAID BILLING SYSTEM FOR PHYSICIANS' SERVICES

With the cooperation of the Medical Services Administration of the State of Alamaba, Blue Cross-Blue Shield of Alabama, and the Equitable Life Assurance Society, the National Center has contracted with the Clinical Information Systems Group of the University of Alabama to design, demonstrate, and evaluate a billing system for medicaid services. The objective of this project was to determine whether the costs to physicians of submitting claims and to insurance carriers of claim processing can be reduced by transmitting claims to a central computer facility from ordinary telephone terminals located in physicians' offices. Instructions and data confirmation are provided from the central computer facility by ordinary voice communication over regular telephone lines. Such a billing system for medicaid services has been implemented and tested in 100 physicians' offices throughout the State of Alabama over a 2½-year period. Participating physicians represented 17 percent of all physicians and 50 percent of the monthly volume of medicaid claims in the State.

The average cost to physicians of manually preparing an insurance claim has been estimated at from $1.25 to $2.50. The experimental system appears to reduce expenses by over one-half, with the average claim costing a physician $0.55 to $0.60, exclusive of terminal rental ($6 per month).

This project has clear implications for any future program of national health insurance. The anticipated cost of processing claims has been a major problem in the design of an effective universal financing mechanism. The on-line billing system offers an innovative approach to this question, reducing these administration costs by over 50 percent.

2. MEDICAL ALGORITHM/PROTOCOL SYSTEMS

Since fiscal year 1970 the National Center has been supporting the development, demonstration, and evaluation of medical protocols for use by physician-extenders in treating routine medical complaints. Work is currently underway at the Dartmouth Medical School and at the MIT Lincoln Laboratory. Essentially, a protocol is a written checklist which guides a physician-extender step-by-step through the examination of a patient with specific medical complaints to a diagnosis and appropriate treatment. These projects seek to ascertain whether it is possible to develop such protocols around accepted medical logic and whether physician-extenders, trained in the use of these protocols, can provide high quality care acceptable to patients at a reduced cost. At the present time, 25 protocols have been developed. Each is being carefully validated by comparison to medical literature, review by expert physicians, clinical trials and follow-up surveys of patient acceptance and outcomes.

It now appears that physician extenders, with significantly less training than physicians, can treat a majority of medical problems which are commonly seen in ambulatory care settings. Using protocols, these nonphysicians have been shown to deliver care of equivalent or superior quality to that provided by doctors. This substitution of less highly paid manpower for physicians results in considerable cost reduction and permits physicians to devote more attention to complex medical problems. The Dartmouth studies suggest further that protocol use may reduce the number of unnecessary lab tests which are performed.

This effort has profound implications. It offers a mechanism for reducing medical costs, for assuring quality medical practice by relatively unsupervised physician-extenders, and for increasing the productivity of health manpower in general. As a byproduct, protocols may prove quite useful in reducing the burden of malpractice suits by providing detailed documentation of patient-provider interactions.

3. COMPUTER-BASED ON-LINE DRUG THERAPY MONITORING SYSTEM

This grant was awarded to Stanford University to demonstrate and evaluate the feasibility of preventing adverse drug interactions by means of a computerized monitoring system. A patient drug file is established for each hospital patient by successively entering each drug prescribed for him. When a new entry is made, the system searches the patient drug file and attempts to determine the possibility of an adverse interaction. When a potential problem is detected, an advisory is generated and attached to the drug package as it leaves the pharmacy. The physician is contacted prior to dispensation of the drug in the case of an emergent problem.

Preliminary findings indicate that 13 to 18 potential drug interactions per day are detected at Stanford University Hospital by the experimental system, representing approximately 15 percent of the patients admitted. Plans are currently underway to evaluate this system in a general community hospital over a 2-year period.

The 1961 report of the FDA task force on prescription drugs concluded that one-seventh of all hospital days and $3 billion per year are devoted to the care of patients who have experienced drug toxicity. One-quarter of these adverse reactions are attributable to drug interaction. The work being conducted under this grant provides a mechanism for improving the quality of health services in this country with a concomitant reduction in costs.

4. COST EFFECTIVENESS POTENTIAL OF A NEW MIC HEALTH CARE TEAM (MISSISSIPPI NURSE MIDWIFE HEALTH CARE TEAM)

With the support of the National Center, the Department of Obstetrics and Gynecology at the University of Mississippi Medical Center is demonstrating and evaluating the Maternal Infant Care team concept. The MIC team uses a nurse-midwife as coordinator and primary staff member of a health care team which includes both an obstetrician and a pediatrician as consultants and a health aide to assist in case-finding, referral, and follow-up. The team provides a full range of antenatal and postnatal services including delivery for low-income women with normal pregnancies.

A study of services provided by certified nurse-midwives in 438 low risk pregnancies has been conducted. Analysis of outcome measures for the prenatal period, labor, delivery, and early infancy, suggest that in hospital settings nurse-midwives with consultant physician back-up provide care equivalent to physician-directed services. Data from Holmes County, Miss., where nurse-midwives supplement the care of local physicians in low risk pregnancies, thus allowing physicians to spend more time with high risk mothers, indicate a significant decline in early infant mortality.

The findings of this effort justify the acceptance of certified nurse-midwives for the care of clinically low risk maternity patients. The extension of the nurse-midwifery education in Mississippi from graduates in 1961 to 40 enrollees per year currently illustrates the acceptance of the program in the Southeast. Presently, 44 graduates are employed in 19 sites, five of which are private practices. A more thorough examination of the costs associated with nurse-midwifery programs is anticipated. Nevertheless, it is reasonable to assume that this innovation has great potential for improving maternal and infant health in this country while reducing the cost of obstetrical and pediatric services.

Mr. FLOOD. All right. Now the budget for this health services research, in that you propose to spend $1,600,000 for planning and regulating analysis. All right; now, how does that differ from the activities where you are asking to provide $7 million under the health planning and resources section of the budget?

Dr. ROSENTHAL. That is probably a good example of how we interact. We have taken the position that the health resources planning activity is directly involved in funneling assistance to the health planning agencies, themselves. We have worked with them to identify areas where the knowledge is not sufficiently advanced to be of use to the individual planning agency——

Mr. FLOOD. You see that stands out like a sore thumb. $1.6 million for this, and you come down here, and you have $7 million for redevelopment of planning methodology, which contains a similar item. There they are. It appears we are talking about the same thing now.

Dr. ROSENTHAL. We are not talking about exactly the same task, although we are talking about things that are directed to the same objective.

COOPERATIVE HEALTH STATISTICAL SYSTEM

Mr. FLOOD. All right; you refer, also, to the cooperative health statistics system. Will you describe that system?

If you had any trouble with consonants, you would have an awful time around here.

Will you describe that system?

Dr. ENDICOTT. Dr. Perrin is our consonant expert.

Dr. PERRIN. That is a program in the National Center for Health Statistics which we have been attempting to develop over the past 4 or 5 years in anticipation of what we feel are the needs for data in decisionmaking processes at the local level. This anticipation appears to be borne out by the health planning legislation, by the comprehensive health insurance programs, the areas in which health data are absolutely necessary for wise decisionmaking locally.

With this system, for the first time the National Center for Health Statistics is accepting the responsibility for something other than gathering data at the national level for purposes at the central Federal level. We are turning our attention to assisting the States and local areas in attempting to build a data system which will provide information for decisionmaking locally and in the States and in the major metropolitan areas. The data are to be summed and sent to the Federal level to serve multiple purposes in a single system. Hence, the cooperative health statistics system.

NUMBER OF STATES PARTICIPATING IN THE COOPERATIVE SYSTEM

Mr. FLOOD. You said 35 States—we are talking about the same thing now—35 States will be participating in the cooperative health statistics system.

When do you anticipate having all 50 using the system?

Dr. ENDICOTT. I think that this is entirely a function of how——

Mr. FLOOD. I was up in Alaska one day, and they called it the lower 49, but I mean the whole 50.

Dr. ENDICOTT. Our chief impediment here in getting forward, sir, is lack of funds. And the States are responding much better than we had anticipated, and modifying their data activities in order to fit into the large scheme. Their ability to do so has been limited by the availability of contract funds in Dr. Perrin's operation.

I have forgotten the precise number, but we had to turn away something like 10 States last year for lack of funds.

Mr. FLOOD. You did point out in your opening statement that if this cooperative statistics system is not expanded and soon, you are going to have a can of worms there. You are going to have a conglomerate of costly and unrelated programs and less efficient data system and all that kind of thing.

Is that happening today? Do you have any evidence that is actually happening now?

Dr. PERRIN. I would say concerning the very question to which you referred earlier, regarding the choice of the health services area, that there is a fundamental statistical issue involved about how you gather the data and from what sources the data are available. We should become directly involved as soon as this kind of activity gets underway to give the type of leadership to avoid the kind of duplication you discuss.

So, yes; it is occurring even now in many, many areas.

Mr. FLOOD. Will the data from this cooperative health statistics be available to the new health planning agencies or will they have to initiate their own statistics system?

I hope they are not doing that.

Dr. PERRIN. We are working very closely with the program, the health planning program, to avoid duplication. The idea currently is to find out immediately what is available, then to identify the gaps and to try to fill those gaps with the cooperative health statistics system.

Mr. FLOOD. You are asking this committee to approve an increase of $3.63 million for the national health care statistics; if we approve this increase, I certainly hope some time in the future we are not going to find out that all of these State planning agencies just went out and established their own separate and competing data system, you know. I wouldn't comment about that. That is a rhetorical question.

Dr. ENDICOTT. I have assigned the basic responsibility for data in the health planning activity to the National Center for Health Statistics.

Mr. FLOOD. What kind of technical assistance—it will be that—will the National Center for the Health Statistics provide for these new health planning agencies, in fiscal year 1976?

Dr. PERRIN. It will be very active within the limits of our resources, sir. Technical assistance requires personnel and within the limits of those resources we will dedicate anything we can scrape together to the health planning effort, because we believe very firmly that this is where the future of health data and the use of health data lie in the health planning activity.

DESIGNATING HEALTH SERVICE AREAS

Mr. FLOOD. In your juistification again, for this new health planning program now, you state the area designating process will be completed by August 1, 1975. How confident are you that that is actually going to be completed by that date?

As I said before, there has been a number of governors, several that I know of, who intend to ask for a waiver of that requirement, that the standard metropolitan statistical areas be designated as a single health service area. Is that going to cause you to miss that target date?

Dr. ENDICOTT. No, sir, I don't believe so. We are holding firm.

Mr. FLOOD. Have you heard from any of the Governors asking for those waivers?

Dr. ENDICOTT. Yes, indeed. I have had two meetings with Governors' representatives within the past 3 weeks, I believe.

Mr. FLOOD. I am not surprised.

Dr. ENDICOTT. That last meeting was in the Under Secretary's Office to discuss the States concerns particularly where the SMSA's cross State boundaries. I think there are 34 standard metropolitan statistical areas that cross State boundaries.

It is our current impression that we are going to have some problems with about 25 or 26. The other two or three States involved have managed to go along with the legislation.

Mr. FLOOD. Have you heard from anybody in Pennsylvania?

Dr. ENDICOTT. I haven't, myself.

Mr. FLOOD. You are going to.

Dr. ENDICOTT. I don't doubt it with the Delaware Valley.

Mr. FLOOD. And up on the northeast.

Dr. ENDICOTT. Oh, yes; that is right.

Mr. FLOOD. Up in that area right there. In the Wilkes-Barre area, they had a great operation going up there, and now they are up against this thing.

I understand in the Lehigh Valley, the areas there are mixed up in this thing. You are going to have a can of worms there.

Dr. ENDICOTT. I was speaking of the ones that cross like Philadelphia, and East Philadelphia.

TRANSITION FUNDING FOR EXISTING AGENCIES

Mr. FLOOD. Doctor, how much transition money is in this budget for the RMP's the regional medical programs, and the comprehensive health planning program, and what period of time does it cover?

Dr. ENDICOTT. The transition money, sir, is all——

Mr. FLOOD. I am going to be breathing down your neck now.

Dr. ENDICOTT. It is all in the supplemental.

Mr. MILLER. Do you mean the interim budget?

Mr. FLOOD. No, I mean exactly what I said, the transition.

Dr. ENDICOTT. The transition between the old and new agencies, that is all in the second supplemental, which your committee and the House has already voted on, sir.

Mr. FLOOD. Suppose you don't have this health systems agencies; suppose you don't have them in place by the end of the calendar year, by December 31, 1975, how will these old programs, now, CHP, the comprehensive health planning thing, and the RMP's, the regional medical programs, how are they going to finance their operations until your HSA is in place, the health service agency?

Dr. ENDICOTT. We would have to come to the committees and request some reprograming of the construction funds or other funds, I suppose, or come in again with the supplemental, because we have budgeted them, as you know, just through December of this year.

Mr. FLOOD. You don't have any rug down there you can look under, or anything at all?

Dr. RORRIE. For the State agency in the supplemental there is $9.5 million for the new State agencies.

Dr. ENDICOTT. But they are the new, not the old ones.

Mr. FLOOD. I mean the old ones, the old CHP's and RMP's.

Dr. ENDICOTT. No, sir; there is virtually no slack in this budget. Unless Mr. Miller has some other trick up his sleeve, we would have two alternatives, reprograming or a supplemental.

Mr. MILLER. There is a third which is more likely, as you know, Mr. Chairman, which is no money at all.

Mr. FLOOD. It depends on what suit he is wearing.

We did appropriate transition funds for the RMP's in the second supplemental. With all of the funds that were appropriated for the RMP's now, will they be obligated by June 30, this June 30?

Dr. RORRIE. Yes, they will. We have sent out instructions to the RMP's and they are submitting applications to us by the 3d of May. We plan to have a review cycle in the middle of June.

Mr. FLOOD. What efforts are you making to arrange with other Federal programs or other State programs to pick up the support for the good RMP? We all know where they are.

Dr. ENDICOTT. I have assigned this as a special responsibility to my deputy, Dr. Margulies, who was at one time, as you know, the director of RMP.

Mr. FLOOD. I know.

Dr. ENDICOTT. We have a situation here in which there is approximately $75 million in the continuing resolution, and, as you know, $50 million in the House passed bill on the second supplemental. We are hoping that it will be clearly indicated in the final action on the second supplemental as to whether the Congress intent is that one replaces the other or that the are additive, so that we will know precisely the amount involved. It is my intention, however, to see to it that we obligate the funds that are finally made available by the end of this fiscal year.

If we get some extension, it would be helpful, but if we don't, we will get the job done by the 30th of June.

STAFFING COSTS OF HEALTH SYSTEMS AGENCIES

Mr. FLOOD. In your justifications you state that it is going to cost an average of $25,000 per position to staff a health system agency?

Dr. ENDICOTT. Yes, sir.

Mr. FLOOD. What salary are you going to pay the director of one of these agencies?

Dr. ENDICOTT. Well, the establishment of the salary scale will be the responsibility of the agency, and it is not our intent to establish the salary scale, but there is one thing that was——

Mr. FLOOD. You are talking $25,000 to staff the system. What are you going to pay the director?

Dr. RORRIE. There is a requirement, sir, that the director and other staff be paid according to the rates prevailing in the area with comparable positions, so the salary will vary by area. For example the salaries in Philadelphia will most likely differ from the slaries in a rural area.

Dr. ENDICOTT. One thing I hope will be avoided——

Mr. FLOOD. You see why I ask the question. What are you going to say?

Dr. ENDICOTT. Almost everyone who studied the old system, the CHP system, attributed many of its deficiencies to the very restrictive salary scales afforded by the State Civil Service Commission and attributed the success of RMP programs to the fact they were able to employ outside that restrictive system.

I believe there was ample illumination of this problem in the congressional hearings on the legislation so that the Congress wisely provided flexibility for the health system agencies to permit them to pay a reasonable income in view of the comparable activities in other areas. If they are too penurious about it, we are going to have the same problem we had before, and that is we won't get the right people in them.

MEDICAL FACILITIES CONSTRUCTION

Mr. FLOOD. You are asking for $100 million for medical facilities modernization and construction. Will any part of that $100 million be used to renovate or upgrade publicly owned nursing homes?

Dr. ENDICOTT. I think it is permissible.

Dr. RORRIE. Twenty-two percent would go to public facilities.

Mr. FLOOD. Does this provide for any assistance at all to private nonprofit nursing homes for modernization and construction?

Dr. ENDICOTT. Yes, sir.

STUDENT LOAN FUNDS

Mr. FLOOD. Does the budget request contain sufficient funds to enable students who have received the loan for an academic year which is ended before July 1, 1974 to continue to complete that education?

Dr. ENDICOTT. Yes, sir. The requests for student assistance, even though we are proposing gradually to phase them out, do contain enough money to continue the support of those who had already been receiving such aid. However, there are new students receiving awards which we made under extension legislation passed in August of 1974 and funds for continued support of these students are not in our request.

Mr. FLOOD. On page 123 of your justifications you say "Schools will continue to make new loans from the funds repaid by prior recipients of Federal loan assistance."

Dr. ENDICOTT. Yes, sir.

Mr. FLOOD. How many new loans will be made from that pool of money?

Dr. ENDICOTT. From the loans repaid?

Mr. FLOOD. Yes. How many new ones will you make from that pool?

Dr. ENDICOTT. May I explain that for the record?

Mr FLOOD. What I want anyhow is a table. Supply for the record a table showing the number of loans in 1976 to health professions and the nursing students, too.

Dr. ENDICOTT. Separately, yes.

[The information follows:]

HEALTH MANPOWER

Loan collections are pooled and used in combination with appropriated funds to make student loan awards. The number of new loans for health professions and nursing students obtained with funds collected would be as follows for 1975 and 1976:

	1975	1976
Heath professions loans:		
Estimated collections	$11,400,000	$13,800,000
Number of new loans supported	9,500	11,500
Nursing loans:		
Estimated collections	$5,500,000	$6,500,000
Numberof new loans supported	6,875	8,125

REDUCING MEDICAL MALPRACTICE CLAIMS

Mr. FLOOD. Also in your opening statement, you said you intend to look at the probability of reducing the number of malpractice claims through such mechanisms as medical arbitration, informed consent. Will you explain how those mechanisms work?

Dr. ENDICOTT. Yes, sir. In the Department, Dr. Roger Egeberg has the lead in the malpractice area, and he has asked HRA to carry out certain activities, one of them in this field. I have assigned the responsibility to Dr. Rosenthal.

Mr. FLOOD. Medical arbitration, informed consent.

Dr. ROSENTHAL. Those are fancy phrases. Medical arbitration is a substitute for taking somebody to court and suing them. There is some suspicion that some of the malpractice claims come from people being dissatisfied with the way they are treated, and the purpose of the study of arbitration is to determine whether or not having something other than a court in which to air grievances will reduce claims.

Mr. FLOOD. How are these mechanisms going to work? Go ahead, you are doing all right.

Dr. ROSENTHAL. There is some experience in HMO's or prepaid group practice with having an ombudsman. If somebody feels they are not treated right, they can come and get somebody to listen and make amends without having to go through a legal battle and having lawyers. We don't have a lot of experience with that, but there is some suspicion it might be an important addition to what is available.

Mr. FLOOD. What is the difference between medical arbitration and informed consent?

Dr. ROSENTHAL. Informed consent really means informing people so that they know what it is they are allowing to be done to them before it gets done, rather than taking a few tests and having it turn out those tests are risky things.

Mr. FLOOD. You are not going to use this medical gobbledygook to tell them what is going to happen to them?

Dr. ROSENTHAL. That is correct. And it is one of the major things you ought to inform the person you want the consent from.

Mr. FLOOD. In understandable language and terminology?

Dr. ROSENTHAL. That is corect.

Mr. FLOOD. Is there anywhere in the country they are using these mechanisms now?

Dr. ROSENTHAL. There are some arbitration experiences in New York and in California.

Mr. FLOOD. We would like the record to show something on those when you get the record back. In the meantime if something comes up about informed consent I certainly think you should devote some time in the record to it by the time we get to the floor with this. You know how fast this whole thing is pyramiding in the courts and everyplace else, consumers associations and bar associations. On that terminology and examples where they are being used, arbitration in certain places, in New York and California, anything at all on this problem.

Do you believe under either one of these mechanisms the interest of the health consumer is going to be adequately protected?

Dr. ROSENTHAL. I think both of them are strategies to enhance the degree to which that interest is protected.

Mr. FLOOD. That is the purpose is it?

Dr. ROSENTHAL. That is correct. "Adequately" is a tough word. "Better" I guess is what we are shooting for.

[The information follows:]

MALPRACTICE ARBITRATION EXPERIENCE

Under an arbitration procedure the plaintiff who is alleging a claim, and the medical service provider against whom the claim is alleged, submit the dispute to one or several persons for a decision as to whether the provider is at fault and is required to pay damages to the claimant.

Arbitration procedures have been employed in the State of California for a number of years. For example, the California Medical Association and the California Hospital Association have been co-sponsors of an arbitration demonstration project since 1961. Their experience has been that almost all patients, upon entering the hospitals involved in the project, do accept the agreement that if any disputes should arise later they will be submitted to arbitration. This has been true of approximately 99% of the 300,000 patients admitted to the hospitals over the period of 1961 to 1973. Also, very few of the patients who so agreed later, upon discharge from the hospital, exercise their option which allows them to void the agreement.

Other arbitration programs in California include the Ross Loos plan, started in 1929, which requires that subscribers to the plan agree to arbitration as the mechanism for resolving disputes. The Kaiser Foundation uses arbitration.

It is difficult to assess objectively the use of arbitration in California, because the number of actual arbitration cases has been so limited. Under the California Medical Association and California Hospital Association program which involves eight hospitals in the Los Angeles area, there have been less than six cases submitted to arbitration, and there are no completed cases as yet. In the San Diego area, which was added to the demonstration program in January, 1974, there have been three cases submitted to arbitration. There is some indication that the cases submitted to arbitration were the ones where the damages claimed were relatively small in dollar amount.

One approach toward assessing the experience of the eight Los Angeles hospitals was undertaken on the basis of comparing these hospitals with eight other hospitals in the area. The number of medical malpractice claims settled, the percentage of claims settled, the total defense costs involved, and other factors for the hospitals which offered arbitration as an option were compared with eight hospitals that did not provide for the use of arbitration. The resulting observation was that the hospitals which offered arbitration had a more favorable overall experience.

However, there are not enough cases of arbitration upon which to base any definite conclusion that arbitration procedures can or should replace court proceedings entirely. The few claims that have been submitted to arbitration were relatively small in dollar amount. Therefore, it is not possible to determine the success,the cost, the fairness of the procedures, and final decisions in those cases that are complex and result in large awards. Without more such data, making binding arbitration a mandatory procedure, even in States where this is constitutionally permitted, might prove to be so inequitable that certain parties would have to receive legislative and judicial relief.

Yet the dilemma, and this is something that must be resolved as a matter of policy, is that claimants and their attorneys generally do not submit claims to binding arbitration where the right to litigate in court is available to them. Therefore, either arbitration procedures must be made more attractive, or there must be limited instances, perhaps under experimental agreements or under some State statutes, where arbitration is made mandatory for a certain period of time. This would permit more extensive and realistic studies of arbitration procedures. Legislation has in fact been introduced in the State of New York to create a Medical Injury Liability Board. This goes beyond their present system of submitting claims to a Medical Mediation Panel. Under the "Mediation" procedure, an active attempt is made by the panel to which the claim is argued to get both sides to compromise, and settle the dispute without going through a formal trial procedure which requires a finding of fault and the

rendering of a verdict. The panel consists of a doctor, whose specialty is one that both sides agree to; an attorney, who represents the New York Bar; and a judge.

In a period when the Medical Mediation Panel procedures were initially being studied, September, 1971 to June, 1974, 529 cases were reviewed. These represented a backlog of cases which were awaiting trial. Of these 529 cases, 141 were settled, 4 were discontinued, and 1 was dismissed. Of the remaining cases, 382 were remanded, that is, placed back on the calendar or sent back to trial, and 1 case is still in the process of possible settlement, pending additional necessary information. The cases disposed of, by means of the Medical Mediation Panel, represented approximately 28% of the total 529 cases that were taken over at the start of the program.

In September, 1974 the Medical Mediation Panel procedure was enacted into law. Also, the New York Supreme Court effected certain changes in procedure on the basis of the experience during the pilot program, namely, the observation that not all cases were suited to being brought before the Medical Mediation Panel. Under the present arrangement, cases are first screened by a judge to determine whether a successful negotiation is likely to be achieved. Cases involving negligence which is not considered to be the type of medical malpractice with which the Mediation Panel should deal, such as those which involve falling out of bed, for example, are referred to the court handling civil suits, where the determination of fault can be resolved on the basis of testimony by an impartial expert. With regard to those cases that will be referred to the Medical Mediation Panel, the screening involves determining that the pre-trial discovery procedures have been accomplished, physical examinations taken, motions made, unnecessary defendants dropped, and the attorneys' agreement obtained as to the specialty of the medical expert.

There are still no records kept of the proceedings, and the panel members cannot testify in any subsequent court action involving the case. The experience following the passage of the law in September, 1974 is that of 237 cases screened, 18 were settled, and another 8 out of the 16 under discussion are expected to be settled. Three cases were referred to a Podiatry Panel; and 25 cases were remanded for trial, without a hearing before the Medical Mediation Panel. Roughly 15% of the cases subjected to arbitration have been settled out of court. This reduction in the precentage of cases settled by the Mediation Panel can be ascribed to the fact that the earlier cases that were received were derived from a backlog of court cases that had been pending for some time. The ones now screened, to go before the Medical Mediation Panel, represent more difficult cases.

Some opinion has been expressed that the mediation proceedings ought to be transcribed, and even allowed as evidence in any subsequent trial. There has in fact been introduced in the New York State Legislature a bill to permit such mediation proceedings to be introduced as evidence in any subsequent trial. However, there is some concern that keeping a record, and allowing it to be introduced as evidence, would destroy the frank and open expression now obtained at the mediation proceedings, which have resulted in the success of settling so many cases without going to court.

The New York State Medical Mediation Panel procedure is believed by those involved with it to be a successful program, in terms of benefiting the courts by achieving a lighter caseload, and benefiting the parties involved by achieving a faster settlement of their dispute. The procedure is also believed to be faster in that the time spent is figured in months rather than the years which court litigation entails.

PROGRAM MANAGEMENT POSITIONS

Mr. FLOOD. Will you also for the record give us a table showing the number of positions assigned to each one of the activities in that program management?

Dr. ENDICOTT. Yes, sir.

Mr. FLOOD. And also the accompanying dollars.

[The information follows:]

DISTRIBUTION OF PROGRAM MANAGEMENT POSITIONS AND DOLLARS BY ACTIVITY

	1975		1976 estimate	
	Positions	Amount	Positions	Amount
National health statistics	44	$1,019,000	44	$1,017,000
Health planning and resources development	460	10,224,000	460	13,090,000
Health services research	224	5,575,000	224	6,344,000
Health manpower	619	24,520,000	619	23,930,000
Health facilities construction [1]				
Office of the Administrator	253	7,529,000	253	7,512,000
Total [2]	1,600	48,867,000	1,600	51,893,000

[1] The staffs associated with this activity are distributed among the health planning and resources development and the health manpower programs.

[2] Includes $42,000 in obligations from the social security trust fund.

FOREIGN MEDICAL GRADUATES

Mr. FLOOD. I have before me now an article from the Washington Post of this morning which states "Delegates of five leading medical groups urge that the number of foreign medical graduates entering the United States be cut in half."

What are you doing about this problem? You may not have had a chance to read that, but you know the problem?

Dr. ENDICOTT. Yes.

Mr. FLOOD. We get a lot of letters and telephone calls because of the meetings here for 2 or 3 days. These were coming from all over. One came from Guadalajara. There are 2,000 or 3,000 Americans in Guadalajara, Mexico, alone, they tell me. Did you see the article this morning?

Dr. ENDICOTT. Yes.

Mr. FLOOD. What are you doing about the problem?

Dr. ENDICOTT. Among other things we helped to finance this conference which the newspaper article is referring to. We believe there are several important issues here which were addressed in the conference.

Mr. FLOOD. We have a half dozen from up in Luzerne County. I got a call from a fellow and his wife in Guadalajara. The fellow was coming up here to protest or intervene or something.

Dr. ENDICOTT. There is no intent whatever to exclude the foreign medical graduate who is competent.

DETERMINING COMPETENCY

Mr. FLOOD. That begs the question who is competent? Who is going to judge the competency?

Dr. ENDICOTT. The conferees recommended, and I fully support, the recommendation that we develop a new talent test which everyone, domestic graduate or foreign medical graduate, must pass satisfactorily before entering internship or residency where he will be delivering services to patients.

Mr. FLOOD. Are you talking about American citizens, American born, or what?

Dr. ENDICOTT. I am talking about American citizens who are graduates of our own medical schools, I am talking about American citizens who are graduates of foreign medical schools, and I am talking about foreigners who are graduates of foreign medical schools. Everyone entering that period of his training when he will be responsible for delivering patient care will be required to perform satisfactorily in the same examination given to everyone. That is No. 1.

No. 2 is to reinstate the exchange visitor program to its initial purpose, which is to permit foreign nationals to come to this country for a brief period of time——

Mr. FLOOD. Brief?

Dr. ENDICOTT. One to two years, to receive special training unavailable in their country and prepare them for careers in their own country. One of the reasons we are having such an influx of foreign medical graduates at the present time is that the immigration laws and regulations have made it possible for people who come here, ostensibly for just training, without going back to their own country to convert to immigrant status and become citizens. The conference advocates, and I strongly support, cleaning up this situation so that the exchange visitor visa is what it was intended to be, and that the training is carefully selected to provide the need their government feels they have in terms of training and to see to it they go back.

Another recommendation, which I feel that those American nationals who are studying abroad would support, would be reiteration of a third track system whereby they would be admitted to advanced standing in our own schools after they complete the first 2 years medical education abroad.

We have had as a policy encouraging the medical schools in the United States to give advanced standing to American nationals who have acquired the first several years of their training abroad and who can successfully pass part one of the test.

Mr. FLOOD. In most cases they do that simply because there aren't enough physical facilities stateside to take care of them regardless of their academic studies.

In this proposal for examination of students from foreign medical schools you are not discriminating against any particular school or any particular country are you?

Dr. ENDICOTT. We are not discriminating against anyone. The proposal here is that everyone take the same examination.

MAINTAINING THE DIVISION OF DENTISTRY

Mr. FLOOD. You recall that this subcommittee expressed very serious concern at the time of the fiscal 1974 appropriations over the apparent effort, we felt, of the Department to dismantle and tear down the division of dentistry. You remember that we wanted to insure that the

important programs of that division were going to be continued under a very strong central administration, and the subcommittee recommended nearly $15 million for the division and specifically instructed the Department to retain and strengthen the activities in that setup.

According to the figures we have here now the Department is requesting at least what appears to be a fiscal 1976 appropriation of only $7.8 million for the whole division. Moreover it is our understanding that the number of people who are going to be directly assigned now to administer the programs of this division have cut in half since 1974.

You certainly should feel called upon to explain to this subcommittee how the Department expects to meet the general responsibilities next year with a budget for the division of less than $8 million. What are you going to use, cigar store coupons or what?

Dr. ENDICOTT. One of the things, Mr. Chairman, that is really difficult to understand is what happened to the Division of Dentistry when I appointed a dentist as a Director of the Bureau which supervised it. He was promoted to be the head of the Office of Dental Affairs in the Assistant Secretary's Office, and his successor as the Bureau Director is also a dentist. I would yield to Dr. Whiteside to fully explain the significance of this. I think there is a good explanation.

Mr. FLOOD. Are you a dentist?

Dr. WHITESIDE. Yes, sir.

The division will have a budget of $7.8 million. It is the request and that is the same as they had available in fiscal 1975.

Mr. FLOOD. How long have you been onboard?

Dr. WHITESIDE. Monday as a full-time Director.

Dr. ENDICOTT. Before that he was my executive officer.

Mr. FLOOD. I just stated about the attitude of the committee, what was done, the language which was written so it could not be misunderstood. It was all in English. What are you going to use, rubber bands? How are you going to do this?

Dr. ENDICOTT. I think the strongest evidence I can offer you, sir, is my honorable intentions with regard to the field of dentistry. I advocated the creation of a special office in the Office of the Assistant Secretary to coordinate dental affairs throughout the Public Health Service and provided both slots and dollars to man it, including its director, Dr. John Greene, who was formerly Director of the Bureau of Health Resource Development, and prior to that Director of the Division of Dental Health.

Mr. FLOOD. Something funny happened on the way to the forum. What was it—OMB or what?

Dr. ENDICOTT. I would like to blame them, because they are not here to defend themselves, but I think that the gradual erosion of staff occurred not only just in the Division of Dentistry. I think if you look at the staffing of all of the component parts of HRA in comparison to the staffing 5 years ago, you will see that the staffs of all have been shrunk in about the same proportion.

Mr. FLOOD. You know that very seldom does this subcommittee in the realm of health specify or spell out and say do this or something. It is very seldom this subcommittee attempts to write language or write a law but they certainly did in this case make very specific the instruction to retain and strengthen the activities of that shop. And here we are.

51-805 O - 75 -- 48

Mr. MILLER. Mr. Chairman, I would like to keep the record open on this one if we may and supplement it, because somehow or another the figure we show for 1974 which is comparable with the $7.8 million figure you quoted is only $8.5 million, which only shows a small reduction. And I believe that part of that $15 million that you appropriated in 1974 is contained elsewhere in our appropriation.

Mr. FLOOD. I said almost $15 million.

Mr. MILLER. I would like to be able to trace that $15 million to where it currently exists, if at all, in the 1976 request.

Mr. FLOOD. You can be sure we will look at it.

Dr. ENDICOTT. I am satisfied there was no specific action taken which is contrary to the committee's instruction.

Mr. FLOOD. In the field of health it is very unusual for this subcommittee to act like that.

Dr. ENDICOTT. I would like to furnish additional information on this topic for the record.

Mr. FLOOD. That would be fine.

[The information follows:]

HEALTH MANPOWER, DIVISION OF DENTISTRY

It is true that in 1973 and 1974 the budget for the Division of Dentistry reflected a program level of approximately $15 million including direct operations funds. Due to a recent change in the method of budget presentation, all direct operations funds were removed from divisional budgets and were shown as a combined agency budget line item. Thus the amount shown for dentistry now only reflects the program funds of $8 million. This program has been maintained at a constant budget level of approximately $15 million for the past 4 years. The dentistry program is an integral part of the administration's overall health manpower program and will continue to be funded.

Mr. FLOOD. Mr. Michel.

POSITION BREAKDOWN

Mr. MICHEL. Of the 478 positions under National Health Statistics, how many are involved in each activity? Could we have some type of breakdown record?

Dr. PERRIN. Yes, I will be happy to supply that for the record.

[The information follows:]

Office of Statistical Research	8
Office of International Statistical Programs	12
Division of Vital Statistics	60
Division of Health Examination Statistics	48
Division of Health Manpower and Facilities Statistics	22
Division of Health Resources Utilization Statistics	38
Division of Health Interview Statistics	31
Division of Analysis	13
Division of Cooperative Health Statistics System	27
Division of Operations	219

Mr. MICHEL. Could you provide a list of the locations of the 19 sites for the short courses presented through the Applied Statistics Training Institute?

Dr. PERRIN. Yes. In fiscal year 1975 the National Center for Health Statistics presented 41 courses through the Applied Statistics Training Institute in the following locations: San Francisco, Calif.; Boston, Mass.; Denver, Colo.; Chicago, Ill.; Indianapolis, Ind.; Philadelphia, Pa.; New Orleans, La.; Columbia, S.C.; Atlanta, Ga.; St. Louis, Mo.; Honolulu, Hawaii; Dallas, Tex.; Nashville, Tenn.; Seattle, Wash.;

Phoenix, Ariz.; Oklahoma City, Okla.; Los Angeles, Calif.; New Haven, Conn.; and Raleigh-Durham, N.C.

COST OF TRAINING

Mr. MICHEL. Regarding the 700 students who enrolled in the training courses, what was the cost per student and who paid their expenses to attend the courses?

Dr. PERRIN. The average Federal cost per student is $350. Traveling expenses and per diem for the students is paid by the State governments which sponsor the students. The travel costs vary depending upon the distance to the training site from the students' normal place of work.

COMPUTER SYSTEM

Mr. MICHEL. What sort of computer system has been developed at the National Center for Health Statistics?

Dr. PERRIN. The NCHS computer system is an IBM 360/50 digital computer which utilizes the operating system called multiprogramming with a variable number of tasks and the Houston automatic spooling priority system. The system also utilizes a timesharing option which allows interaction with the computer by analysts and programers through several terminals. The basic hardware configuration consists primarily of: A central processor unit made up of an IBM 360/50 with 256K bytes augmented by 256K bytes of additional storage manufactured by Electronic Magnetics and Memories and 1,024K bytes manufactured by Ampex; eight tape drives; card reader; card reader-punch, printer; and three banks of disk drives, one manufactured by Memorex and the other two by IBM. The basic system was first installed in 1967 and is, for the most part, wholly owned, not leased. It is estimated that the Government has realized a savings of approximately $1,200,000, the difference between the actual purchase price and what would have been paid in rentals to date had the system been leased.

Mr. MICHEL. Do you anticipate that the current system will be sufficient to meet your eventual needs?

Dr. PERRIN. By adding modules, as required since 1967, the system is adequate for current needs. It is anticipated that the present system will be good at least 5 more years provided that we are permitted to add modules from time to time as the needs arise.

Mr. MICHEL. Is there any effort underway to consider the feasibility of combining the Center's computer capabilities with that of the National Library of Medicine?

Dr. PERRIN. While no specific effort is underway to consider combining the NCHS computer with that of the National Library of Medicine, we are in the process of designing the necessary telecommunications networks to allow interlinking of computers, so that capabilities which exist in other computer installations can be utilized by NCHS, and the NCHS computer and peripheral equipment can be accessed by other installations. Such a telecommunications link might, for example, allow NCHS access to the National Library of Medicine's information storage and retrieval systems when needed, while allowing other agencies, including the National Library of Medicine, to take advantage of the scientific statistical data processing and large-file manipulation capabilities of the NCHS computer.

COST OF COOPERATIVE HEALTH STATISTICS SYSTEMS

Mr. MICHEL. You say that $3,315,000 will continue the development of the cooperative health statistics system by funding the Federal share of State data collection systems, supporting developmental projects undertaken by the States, and providing technical assistance to the States. Do you have any estimates as to what the total cost of setting up the system will be and what the ultimate Federal share will be?

Dr. PERRIN. We estimate that by 1987 the system could be implemented in all 50 States in the areas of vital statistics, manpower data, facilities data, hospital discharge data, ambulatory care data, and long-term care data. At that time the Federal share would be about $60 million. The State's share would be about $90 million, bringing the total cost to approximately $150 million.

Mr. MICHEL. With regard to the establishment of the first 200 new health systems agencies, you say the funding will support approximately 6.5 professional and 2.5 clerical staff for each with an average cost per position of $25,000, including a wide range of activities. What will the salary level be of these people? Could you provide us with an average for both professional and clerical?

Dr. RORRIE. I will be happy to supply that information for the record.

[The information follows:]

Staff:	Salary
Executive Director	$25,000
Deputy Director	24,000
Senior professional staff (2, $22,000 each)	44,000
Junior professional staff (3, $17,000 each)	51,000
Clerical (2, $7,000 each)	14,000
Total (9)	158,000

The above is the recomended staffing requirements and average salaries for a conditionally designated HSA serving an area with a population of 1.1 million individuals.

Salary and fringe benefits will be approximately 75 percent of an average conditional HSA's first-year budget of $225,000. The average cost per position of $25,000 includes salaries, fringe benefits, overhead costs, and costs related to the performance of the agency functions of health plan development, review and approval of the proposed use of Federal funds, and review of the need for an appropriateness of new and existing health services.

PERSONNEL

Mr. MICHEL. Who decides how many people will be required in each individual HSA, and how will salary levels be determined?

Dr. RORRIE. Section 1512(b)(2)(B) gives us guidance on the number of professional staff an HSA should have. It states that the size of the professional staff shall not be less than the quotient of the population of the health service area divided by 100,000 and that no HSA should have fewer than five professional staff members. For example, an average HSA serving an area with a population of 1.1 million would be required to have a minimum professional staff of 11 when fully designated. It is estimated that a professional staff of 11 would require a support staff of 3. According to the law, salary levels are to be de-

termined by the prevailing rate of pay in the health service area for similar positions in public or private health service entities. We do not believe that we can develop salary scales for the entire country, but we are currently developing a guide for HSA's on how to determine the prevailing rate of pay in their areas.

NUMBER OF HEALTH SYSTEMS AGENCIES

Mr. MICHEL. What will be the final number of health systems agencies when the system is totally operational and how many personnel will be involved?

Dr. RORRIE. It is estimated that the number of HSA's designated in fiscal year 1976 will be between 200 and 250. The final number of HSA's will be the same unless the health service areas are redesignated. If 200 HSA's are designated, the most desirable staffing level projected for an HSA serving an area with a population of 1.1 million appears at this time to be 18 (14 professionals, 4 clerical). Thus, the total number of personnel involved would be 3,600 (2,800 professionals, 800 clerical).

Mr. MICHEL. How does this compare with the number of agencies and personnel involved in the predecessor local planning agencies?

Dr. RORRIE. A survey of 218 CHP(b) agencies, 53 RMP's, and 19 EHSDS agencies taken last year showed that the staff was approximately 2,925 (1,836 professionals, 1,089 clerical).

STAFFING FOR STATE HEALTH PLANNING AND RESOURCES DEVELOPMENT AGENCIES

Mr. MICHEL. Could you provide the same statistics for the State health planning and resources development agencies?

Dr. RORRIE. The most desirable staffing pattern for State agencies will vary with the size of the State. The total projected staff for State agencies is 1,563—1,185 professionals, 378 clerical. A survey of the current staffing requirements of CHP(a), Hill-Burton and the section 1122 designated planning agencies has shown that 1,413 individuals—1,032 professionals, 381 clericals—are engaged in State level activities. The increase in the projected staffing requirements is due to the increased workload associated with implementing the certificate of need function in each State.

CONTRACTING AUTHORITY

Mr. MICHEL. Where will the contract authority lie in this process? Will the local agencies be responsible for most activities?

Dr. RORRIE. Both the HSA and State agency have authority for contracting. However, neither entity may delegate its responsibilities or authorities to a contractor. Contracting should be limited to specific planning purposes. Regulations are being developed which will further define the agencies' authority.

REVIEW AUTHORITY

Mr. MICHEL. What is the extent of our review authority once all the local agencies and the State agencies are in full operation?

Dr. RORRIE. The Secretary has the authority to review the annual budget of each Health Systems Agency (HSA) and State Agency (SA). Performance standards are being developed to cover the structure, operation and performance of the functions of HSA's and SA's. At least once in every 3 years each HSA and SA must be reviewed in detail to determine their conformance with the performance standards. This review must assess the adequacy of the applicable health systems planning (HSP), areawide implementation plan (AIP) and State plans in developing a healthful environment and increasing the accessibility, acceptability and quality of health services at a reasonable cost. Each agencies' structure, operation, and functions will be examined to see if they meet the requirements of the law. The representativeness and functioning of the HSA governing body and Statewide Health Coordinating Council (SHCC) will be reviewed. The professional credentials and competence of the agency staff will be reviewed to determine if they meet the standards established by the Secretary. The HSA's data acquisition procedures will be examined for their utility in developing data to support the HSP and AIP. In addition, the resource development functions of the HSA's and SA's will be studied to determine the extent to which they meet the goals of the applicable health plan in improving the health of the residents, improving the accessibility, acceptability, continuity and quality of health care and restraining health care costs.

CAPITAL EXPENDITURE REVIEWS

Mr. MICHEL. Could you expand on just how the capital expenditure reviews activity is carried out? How have you been able to effect such savings?

Dr. RORRIE. The capital expenditure review program that has been going under authority of section 1122 requires a health care facility or HMO which proposes to make a capital expenditure which is covered, submit its proposal to the State's Designated Planning Agency, the DPA, 90 days in advance of making it, or between 60 and 90 days ahead of time if they are proposing to actually make that expenditure in that period. The DPA then forwards the proposal to the local health planning agency for review and recommendation as to whether it conforms to the plans, criteria, and standards adopted under the Public Health Service Act. At the same time, it forwards the proposal to the State Hill-Burton agency or State comprehensive health planning agency, whichever is not the DPA itself, and to any other concerned State agency. On receiving recommendations from these other agencies the State DPA then makes its finding as to whether the proposal meets the plans, criteria, and standards it has adopted. The criteria employed include, at a minimum, the need of the community in terms of health services required, whether the proposed project can be adequately staffed and operated, the economic feasibility of the proposed capital expenditure and whether it can be accommodated in the patient charge structure without unreasonable increases and finally whether the project will foster cost containment or improve quality of care through improved efficiency and productivity.

Some of the savings in such a review program come from proposed expenditures which are disapproved and which then do not take place.

We estimate that over $200 million was saved in this manner in 1974. There are also other savings which come from proposals which are withdrawn or which are never submitted. This occurs when the health care facilities discuss proposals informally with the staff members of the health planning agencies and find that proposals they are contemplating would have little or no chance of approval. The amount of savings of this sort is, of course, very difficult to estimate.

SELECTION OF STATEWIDE HEALTH COORDINATING COUNCIL

Mr. MICHEL. How will the members of the Statewide Health Coordinating Council be chosen and what will be their role?

Dr. RORRIE. The Statewide Health Coordinating Council (SHCC) will be chosen by the Governor of the State. At least 60 percent of the members will be chosen from a list of candidates nominated by the HSA's. The Governor will appoint the remaining members of the SHCC as he deems appropriate. The SHCC's functions include approval of the State health plan and the State medical facilities plan, review of HSA budgets and grant applications, and review and approval/disapproval of State plans and applications for Federal funds to States under the Public Health Service Act, Community Mental Health Centers Act or Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

GUIDELINES FOR ALLOTMENT DISTRIBUTION

Mr. MICHEL. You indicate that the allotments to the States under the medical facilities modernization and construction funds will be determined on the basis of population, financial need, and the need for medical facilities projects. Have you developed any guidelines as of yet to determine the distribution of the allotments?

Dr. RORRIE. There are certain criteria specified in the law regarding allotments to States. We are developing further guidance with respect to those criteria which we hope to issue sometime early in fiscal year 1976.

Mr. MICHEL. Will every State be getting some money or could the determination be made that some States have no need for these funds and, consequently would not receive any funds under this allotment?

Dr. RORRIE. The statute provides that each State shall receive a minimum allotment from the formula of $1 million.

STAFFING OF PLANNING METHODS DEVELOPMENT PROGRAMS

Mr. MICHEL. With respect to the request for the new planning methods development program, to be funded at $7 million, how many people will be utilized "through a wide-ranging combination of Federal staff * * * ?" How much of the work do you expect to be done through contract work, and how much money are we talking about here?

Dr. RORRIE. The planning methods development program will focus on the development of the "how to" of health planning. The state of the art of health planning is in its infancy and will require a substantial investment over time if it is to be advanced. Our plan calls

for the use of resources from several sources, including: (1) Centers for health planning, as required by legislation, will work to develop planning methods and provide consultation to the field; (2) grants and contracts will be used to help develop specific tools and techniques needed by HSA's and State Health Planning and Development Agency SHPDA's; (3) the Center for Health Planning Information, using Federal and private staff resources, will provide a clearinghouse and dissemination mechanism for information about planning methods; and (4) Federal staff will develop and manage this program. This staff will coordinate the operation of the Center for Health Planning Information as well as guide the work of the Centers for Health Planning and contractors. And $7 million will be used in fiscal year 1976 to support this program. A majority of the work will be carried out through contracts.

MINIMUM DATA

Mr. MICHEL. According to your justifications, HEW will provide materials to the health systems agencies regarding the specifications of minimum data needed to determine such things as the health status of the residents of an area, the status of the health resources and services of such an area, and the utilization of health resources and services in the areas. What kind of criteria are already available which can be used as appropriate guidelines?

Dr. RORRIE. Minimum data sets have already been developed for the cooperative health statistics system of the National Center for Health Statistics. While these were designed for the purposes other than health planning, they will provide a starting point. We are also planning to build upon the current practice in the field as it relates to determining health status, the status of resources, and the utilization of resources. In this process, we will help the health systems agencies determine the major questions they should answer, and the data they needed to develop adequate answers as well as suggest approaches to acquiring that data.

Equally or perhaps more important is the need to develop methods and techniques to use data which is acquired. While we can collect indicators of health status, for example, it is a much more difficult task to measure changes in status over time and relate them to planning actions. Guidance materials in this and many other areas of the "how to" of planning have yet to be developed. We are establishing a major program in this area so that health systems agencies will have the technical base to do their jobs.

DECREASE IN RESEARCH FUNDING

Mr. MICHEL. In view of the current debate and push for establishment of a National Health Insurance plan, how do you justify a $1 million decrease for research in this area?

Dr. ROSENTHAL. In 1975, the National Center will spend an estimated $3 million for various studies of health insurance. This level of expenditure represents 7.7 percent of the total budget of the National Center. In 1976, the National Center plans to spend $2 million for research on this same issue. However, given the level of

funding for the National Center requested in the President's budget, the $2 million expenditure will constitute 8.2 percent of the total budget. That is, the Center does plan to spend proportionately more of its resources on this issue in the coming year. It should also be pointed out that the issues in the health services area are interdependent, and many studies which are described as addressing other issues such as quality, inflation, and productivity, and the disadvantaged, have immediate relevance for the health insurance problem.

RESULTS OF RESEARCH

Mr. MICHEL. Has our completed research in the health insurance field yielded any significant conclusions to date?

Dr. ROSENTHAL. The National Center for Health Services Research has consistently devoted a significant portion of its budget to analyzing the economic implications of a universal financing mechanism of health services in this country. The issue remains a matter of high priority.

Completed research has already contributed significantly to an understanding. For instance, we know that a comprehensive insurance program would affect the hospital and ambulatory care sectors quite differently. Hospitalization insurance is already very extensive, and hospitals are currently operating at historically low levels of capacity. As a result, NHI is not expected to affect drastically either the demand for or the price of hospital services. On the other hand, coverage of ambulatory services is less extensive, and the ability of the existing pool of physicians to expand their production of services is far more limited. Thus, we could anticipate that NHI will probably result in increased demand for ambulatory services. This could result in increased costs for these services because the existing ambulatory facilities may not be able to expand rapidly enough.

The impact of NHI in the ambulatory care sector is a source of major concern. Price increases could also increase physician income and actually shrink the supply of services by reducing the incentive to work on the part of providers. Research activities at the University of Florida now suggest that this effect will be far less than originally anticipated. Furthermore, the expected growth in the supply of physicians implies that the excess of demand over supply will be significantly reduced by 1980.

We will be happy to furnish for the record examples of research currently being supported by the National Center.

[The information follows:]

RESEARCH PROJECTS RELATED TO NATIONAL HEALTH INSURANCE

Most of the research either supported or undertaken by the National Center can be related to some aspect of the National Health Insurance question. Three studies are typical of the projects which address NHI in a most immediate fashion.

The first is entitled "An Econometric Analysis of the Effects of Health Insurance and Supply Factors on the Provision of Hospital Services." Its objective is to develop and test a behavioral model which emphasizes the joint nature of hospital decisionmaking by patients and their physicians. The model includes the patients insurance status and should provide insights about the demand response of both physicians and patients to varying types of third-party payment schemes.

The second is entitled "The Effects of Medicare on Physician Utilization." This is a study of the effects of the introduction of a compulsory, universal health services insurance program, medicare, in the Province of Quebec on the volume and distribution of physician services, the quality of medical care, accessibility of medical care, public satisfaction with medical care, probable health improvements, the practice of medicine, and the use of hospital and clinic facilities. The anlysis should provide some objective information that will guide U.S. policy with regard to National Health Insurance by studying in detail the experience with such a plan in an area very similar to many large metropolitan areas of the United States.

The third project is entitled "An Analysis of Group Practice Efficiency." The purpose of this study is to investigate the relationships of group practice characteristics such as cost-sharing arrangements, physician remuneration methods, presence of business managers, size, and specialty composition to key economic variables such as prices charged to consumers, the cost of physicians' services, the supply of physicians services, and physicians productivity. Of special relevance to the policy issues surrounding NHI is the inclusion of an examination of patient payment mechanism—fee-for-service, prepayment, prepayment with coinsurance or deductibles—on the four key variables, holding other factors constant.

MANPOWER NEEDS

Mr. MICHEL. What is your assessment of the health manpower needs in the country? In which areas are there the greatest shortages?

Dr. ENDICOTT. The supply of most categories of health manpower has been increasing in recent years in relation to population. It is difficult to assess the overall adequacy of the numbers of various health practitioners to provide the health care needed by the American people. These needs depend on the health status of the population and on people's perceptions of the need for care. At present there is no way to measure these factors accurately. Although there is no general agreement on what is an adequate supply of the various categories of health manpower, there is marked unevenness in the geographic distribution of health manpower in relation to population. For example, the ratio of M.D.'s providing patient care per 100,000 population varied from 195 in New York to only 70 in South Dakota in 1973. Distribution is also uneven between urban areas of different sizes and nonurban areas. It is generally agreed that there is a shortage of health manpower, especially physicians, to provide primary care. In the case of some health occupations such as nursing there probably are enough practitioners but a need does exist for more nurses in primary-care services and there are inadequacies in geographic distribution.

If there should be major changes in the health-care delivery system in the country, such as passage of National Health Insurance legislation or greater growth of health maintenance organizations, the need for health manpower would be affected.

Mr. MICHEL. What steps are you taking to insure more efficient use of personnel in the manpower field?

Dr. ENDICOTT. There is sufficient evidence, based on demonstrations, that certain health services can be provided adequately and safely by persons, such as physician extenders, whose training is less time consuming and costly than the physician's. Since 1972, HRA has supported programs producing an estimated 2,200 physician's assistant graduates. The current plan is to continue support at this rate through 1981. This will permit an evaluation of the impact of health-care extenders on the health-care system in terms of quality of care rendered, acceptance, and utilization.

Beyond support for physician's assistants training programs, in fiscal year 1975, other health manpower programs are focused on projects demonstrating the concept of the team approach to the delivery of primary health care. Emphasis will be placed on preventive and primary care training of health professionals, the continued development of primary-health-care team training and methods of humanizing the services provided by health practitioners. The comprehensive nature of primary care includes a large number of tasks which cannot be carried out effectively by one person. The necessity of team delivery in primary care is accentuated by the need for health practitioners who have been trained to maximize the skills of the primary care team.

COST OF HEALTH EDUCATION

Mr. MICHEL. Do you have any statistics on the average cost of educating an individual in a particular health field? Considering the average incomes for various groups, how long does it take for someone to recoup their training expenses?

Dr. ENDICOTT. A study by the Bureau of Health Resources Development in 1970 and 1971 on how health professions students finance their professional educations reported average annual expenses for that year. Based on these annual figures, it is estimated that total expenses would have ranged from about $15,000 for pharmacy students to $27,000 for students of osteopathic medicine. Substantial portions of these expenses are met by obtaining loans. In the 4 years since the 1970–71 survey, tuition and fees have risen sharply and inflation has greatly increased the student expenses for books, food, and lodging. We are planning to make a new survey in the 1975–76 academic year to obtain current data on student expenses.

For medicine and osteopathic medicine, most students spend 3 to 5 years or more in graduate study after graduation and during this time earn very modest salaries. Those who go into private practice upon completion of this graduate training then face the expense of furnishing and outfitting their offices, a substantial outlay frequently met by increasing their indebtedness.

The American Medical Association reported the average net income of office-based physicians was $48,400 in 1973. Information is not available on increases in income by year of practice.

NATIONAL HEALTH SERVICE SCHOLARSHIP PROGRAM

Mr. MICHEL. In regard to the national health service scholarship program, how many scholarships will you fund in fiscal year 1976 and how will this compare to previous years?

Dr. ENDICOTT. We estimated that 2,240 medical and osteopathy students will be supported in fiscal year 1976, the same number as in fiscal year 1975. In fiscal year 1974 funds supported only 371 students.

Mr. MICHEL. Thank you.

Mr. FLOOD. Mr. Conte.

VETERINARIAN SHORTAGE

Mr. CONTE. Dr. Endicott, can you tell me whether there is is shortage of veterinarians in this country?

Dr. ENDICOTT. In 1970, there were about 26,000 active veterinarians in the United States, or 12.7 per 100,000 population. The American Veterinary Medical Association has estimated that a ratio of 17.5 veterinarians per 100,000 population is needed to provide for animal practices, consumer protection programs, public health programs, and research. A study of the National Academy of Sciences in 1972 estimated that a shortage of veterinarians would exist, at least, through 1980.

Mr. CONTE. Is the Health Resources Administration doing anything to support veterinary studies? How much do you intend to spend in 1976?

Dr. ENDICOTT. In 1974, $469,800 was awarded for minority, low-income and rural enrollment increases for veterinarians. Also, $88,400 was awarded for new roles or types or levels of health personnel and $270,000 for curriculum improvements in veterinary medicine.

In 1975, a pending contract for approximately $90,000 entitled "A description of the responsibilities of veterinarians as they relate directly to human health," is planned.

No funds will be allocated in the 1976 President's budget to support veterinarians' studies.

NATIONAL HEALTH INSURANCE

Mr. CONTE. Dr. Endicott, in your statement you indicated that much of your activity was being carried out in preparation for National Health Insurance. Does the administration have a National Health Insurance proposal, and if it does, what does it cover?

Dr. ENDICOTT. Although the current economic situation has made it inadvisable for the administration to actively pursue National Health Insurance this year, the Department remains committed to the basic principles of the comprehensive health insurance plan (CHIP). We are still convinced of the significance of the generic issues surrounding NHI and expect that an administration proposal will be introduced early in 1975.

We believe that the intervening time should be used to build a consensus for a comprehensive program which will provide coverage for the entire population. In addition, of course, we are giving major emphasis this year to implementation of Public Law 93-641, the National Health Planning and Resources Development Act. The work of the new local and State planning agencies and the National Council authorized by this legislation should significantly strengthen the capacity of the delivery system to respond effectively when NHI is initiated.

COPING WITH HEALTH PROBLEMS

Mr. CONTE. You mentioned some of the problems we face in health care—increasing costs, the maintenance of quality, and so forth. Would you tell me what has been done so far in these areas, and what you plan to do in the coming year?

Dr. ROSENTHAL. The National Center for Health Services Research has identified a number of research areas where answers are needed on how more equitably and effectively to finance and manage the Nation's health care system. Specifically, these include the development

of new approaches to increase productivity, equalize access and reduce costs, improving the technology for planning and regulation, greater emphasis on the labor market behavior of nonprofessional manpower, and integrating chronic illness and long term health care more effectively and efficiently into the rest of the health delivery system.

HEALTH SERVICES RESEARCH CENTERS

Mr. CONTE. Would you tell me more about the work carried out in your health services research centers?

Dr. ROSENTHAL. Since 1969 the National Center for Health Services Research has supported a limited number of health services research center programs in which research activities are pursued on a larger and more intensive scale than is feasible under the usual research grant mechanism. In the past, centers have typically been located in academic or research institutions and have carried out a mix of research, education, and consultant activities around specific research foci such as emergency medical services and quality assessment. Centers are directed by well-established prestigious senior investigators who assemble a multidisciplinary staff of researchers to work on a particular problem area.

The National Center has announced a new center's program and it is anticipated that the initial awards for this new generation of centers will be made by late summer of 1975. These centers will be expected to conduct multidisciplinary health services research but are required to structure their research programs around the regional and local problems of their own communities. In addition, they are expected to devote a considerable amount of time to providing consultation and technical assistance to appropriate groups and individuals in their locales. Because these centers will be located in academic or research institutions, they offer unique opportunities for actively participating in and learning from health services research activities to people interested in acquiring new skills or additional education. In short, the National Center views these health services research centers as organizations conducting research and related activities of a variety similar to that found within the National Center. The primary difference is that the National Center must respond to national problems and priorities while health services research centers are free to address issues of more immediate concern on the local level.

HEALTH MANPOWER

Mr. CONTE. You mentioned health manpower projections in your opening statement. Are the increases of 74 percent in nursing and 50 percent in medicine estimates of demand for manpower or estimated of supply?

Dr. ENDICOTT. These are supply projections.

Mr. CONTE. Are you saying that we will have this kind of increase even if we phase out training programs and support as provided for in this budget?

Dr. ENDICOTT. The administration feels it is providing adequate support to health professional training. Our policy has a number of objectives. We wish to encourage the maintenance of existing enroll-

ment levels in critical health professional schools. We wish to target Federal support to resolve the major distributional problems which face us. We wish to increase provider productivity through the more efficient use of paramedical personnel. And, finally, we wish to reduce what we feel are unnecessary and inequitable Federal subsidies to both institutions and students.

Mr. CONTE. How do you propose to improve the distribution of health care workers?

Dr. ENDICOTT. The family medicine residency program has attracted many young doctors. These doctors will be serving the health needs in the communities where they live. This is one way of improving the distribution of health care services. Another is through our National Health Service scholarships program which would have a significant impact on the distribution problem since this program requires 1 year of service in areas of need for each year of academic training received. Our loan repayment program also alleviates the maldistribution problem by repaying from 60 percent to 85 percent of educational loans to health professional and nursing students who work in designated shortage areas.

Mr. CONTE. Would you provide some statistics to show how you are expanding your support to train specialists in family medicine, nurse practitioners, physician assistants, and dental therapists—in fact, for all categories of health personnel in which you see a need to increase the supply?

Dr. ENDICOTT. I will be happy to supply that information.

[The information follows:]

	1975 continuing resolution		1976 President's budget	
	Students	Amount	Students	Amount
Primary care physicians			290	$12,000,000
Family medicine residencies	1,500	$9,500,000	3,000	27,000,000
Physician assistants	2,000	6,300,000	3,100	9,500,000
Dental therapists	500	1,700,000	620	2,500,000

COMPETENCY OF HEALTH PROFESSIONALS

Mr. CONTE. You said that you were examining the problems of maintaining competency among health professionals. Exactly what are you looking at? What have you come up with so far?

Dr. ENDICOTT. We participated in a recent conference with delegates of five leading medical groups on the subject of foreign medical graduates. The conferees recommended, and I fully support this recommendation, that we develop a new talent test which every medical graduate must pass satisfactorily before entering internship or residency. This would include American citizens who graduate from our own medical schools, American citizens who graduate from foreign medical schools, and foreigners who graduate from foreign medical schools. We also support the reinstatement of the exchange visitor program to its initial purpose, which is to permit foreign nationals to come to this country only for a brief period of time to receive special training unavailable in their country to prepare them for practice in their own country.

MEDICAL MALPRACTICE INSURANCE

Mr. CONTE. What do you think should and can be done about the current crisis in the price and availability of medical malpractice insurance?

Dr. ENDICOTT. The availability of medical malpractice insurance is basically a State problem which is currently being addressed through legislative proposals relating to the more critical issues. Some States have already passed such legislation while in others it is pending. Examples of such measures are proposals permitting professional groups to become self-insurers where carriers have already announced termination of their business, and placing safeguards through tort system modifications to control awards.

The premium or price problem is as yet undefined and requires information and data not presently available. The carriers and the Department of Health, Education, and Welfare through Health Resources Administration, are addressing this problem currently. Planning is taking place regarding the kinds of data required and ways and means for collecting it. There just is not useful data available on the consequences of employing alternatives to the tort system such as no-fault and arbitration for handling claims of malpractice. While greater emphasis is being placed on preventive measures, there is a need to design data-gathering plans for evaluating them.

COOPERATIVE HEALTH STATISTICS SYSTEM

Mr. CONTE. Would you expand upon the organization and use of the Cooperative Health Statistics System?

Dr. ENDICOTT. I would like Dr. Perrin, Director of the National Center for Health Statistics to answer that.

Dr. PERRIN. Thank you. The Cooperative Health Statistics System is designed to provide the framework for a coalition among National, State, and local governmental levels for the production of comparable and uniform health information and statistics. Input is obtained from data users at these geopolitical levels regarding data they need, turnaround time they require, and required frequency, reliability, et cetera. The agreed upon data items need be collected only once by the level best equipped to collect them and the data is then shared with all users. This should result in savings in data collection costs, a greatly reduced burden on data providers, and more important, data will be comparable and in the requisite detail for most uses by all participants in the system. The National Center for Health Statistics has the responsibility for providing national leadership by coordinating data collection activities among Federal agencies and between the Federal Government and the States, and in assuring the quality and comparability of data collected. The data produced by the System will be used by health policymakers, health planners, and program evaluators at all governmental levels. Currently the data these groups must base their decisions on comes from a variety of sources and is of variable quality and completeness. The Cooperative Health Statistics System will provide our health programs and decisionmakers with high quality, comparable and uniform health information in the most economical way possible.

Mr. CONTE. When will this System be complete, and exactly what sort of coverage will it include when completed?

Dr. PERRIN. We currently have 30 States providing data to the Federal Government through the Cooperative Health Statistics System. If our appropriations request is granted we anticipate having 42 States providing data by the end of fiscal year 1976 and all States will be participating in one or more of the data components of the System by fiscal year 1977. We further estimate that by 1987 we will have all States providing comparable data in the areas of vital events, health manpower, health facilities, short-term hospital care, long-term medical care, and ambulatory medical care.

Mr. CONTE. Do you believe that adequate funding has been provided for the transition to the new system? Are there any requests for further transitional funding in this budget?

Dr. RORRIE. The Department of Health, Education, and Welfare has requested the following amounts for fiscal year 1975: $18.7 million for Health Resources Planning and Development; $16.9 million for 314 (b) agencies; $12.5 million for 314(a) agencies; $12 million for RMP; and $0.8 million for Experimental Health Service Delivery Systems.

It is our determination that these amounts would prove adequate for the transition to the new system.

The House has approved an additional $38 million for the regional medical programs. The $50 million total for RMP contemplated in the House appropriation is considered more than adequate.

The $12.5 million requested for 314(a) agencies will carry these agencies through June 30, 1975. It is anticipated that $5.5 million of the Health Planning and Resources Development supplemental appropriation will be utilized to support 314(a) agencies through December 31, 1975.

The $16.9 million requested for 134(b) agencies will support these organizations at their current levels through December 31, 1975. It is expected that at that time new health systems agencies will be established in many areas of the country. This request is based on the fact that in 1974 the average monthly cost of operating the 314(b) agencies was $2 million dollars.

The additional $.9 million dollars requested will assist in offsetting increased costs of operation.

The $.8 million dollars requested for Experimental Health Service Delivery Systems will provide minimum support for these agencies through December 31, 1975. Current contracts with the EHSDS run through September 30, 1975, therefore, the additional $.8 million will provide support for the last 3-month period. At this point we believe we will meet the projected schedule.

FAMILY PLANNING REPORTING SYSTEM

Mr. CONTE. Under the National Health Statistics Category, can you tell me what the Family Planning Reporting System is?

Dr. PERRIN. The National Reporting System for Family Planning Services is a continuing program that collects and tabulates demographic and medical service statistics about persons who receive family planning services in a clinic setting. The system also provides statistics on the available services and other characteristics of clinics and projects through which these persons are served. Projects which participate in the program are funded by both Federal and nonFederal sources.

Mr. CONTE. How is the information which it generates used?

Dr. PERRIN. The information generated by the reporting system is used for research, management, evaluation, and planning purposes by a wide variety of consumers. The 5,000 clinics, Federal projects, regional offices, State health departments, State maternal and child health directors, Planned Parenthood-World Population and their affiliates, and the Bureau of Community Health Services are the primary users of the data for management and evaluation purposes. The Congress, the Office of the Secretary, Department of Health, Education, and Welfare, Bureau of Community Health Services, and Planned Parenthood-World Population also use the statistics for planning and budgeting purposes. Public Law 91-572 requires that the Secretary, Department of Health, Education, and Welfare, submit an annual report to Congress on family planning programs and the Family Planning Reporting System provides substantial statistical data for this report. In addition, there is a wide range of persons and agencies which have frequently requested and used the statistics for marketing and demographic research purposes.

IMPLEMENTATION OF HEALTH PLANNING AND RESOURCES

Mr. CONTE. Can you give me a progress report on the implementation of the Health Planning and Resources Development Act? Will all the parts of the new system be operating by the mandated deadlines?

Dr. RORRIE. At the present time all major activities required to implement the act are on schedule. However, it is essential that additional resources be provided in order to support and administer the many activities which are required by the act. In our judgement, the resources requested for fiscal year 1975 and fiscal year 1976 represent the minimum requirements for timely implementation of the act.

Mr. CONTE. In the medical facilities modernization and construction item, can these funds be used to bring nursing homes into compliance with life-safety code provisions? Is there any provision for delaying stricter enforcement of regulations pending the allocation of modernization funds?

Dr. RORRIE. Hill-Burton funds may be used by eligible projects for modernization to provide compliance with NFPA. Eligible projects include hospitals, long-term-care units, outpatients, etc. Long-term-care units are basically skilled nursing homes related to a hospital. Nursing homes used primarily for residency are not eligible. Most nursing homes that have problems fall into the latter noneligible category. There is a separate loan program for bringing nursing homes into compliance with medicaid/medicare code requirements.

Mr. CONTE. On page 176 of your justification you have a chart of health facilities construction allotments for 1976. Would you provide a chart similar in format showing the facilities construction allotments for 1973, 1974, and 1975?

Dr. RORRIE. Hill-Burton final allocations for fiscal year 1973 and fiscal year 1974 are available. Since DHEW did not request title XVI construction assistance funds for fiscal year 1975 and title VI was dropped from the continuing resolution appropriation, no allocation for fiscal year 1975 has been made.

[The information requested follows.]

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FISCAL YEAR 1973 GRANT ALLOCATIONS TO STATES
FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES

	Total	Modernization	Hospitals and Public Health Centers	Long-Term Care Facilities	Outpatient Facilities	Rehabilitation Facilities
Total	$197,200,000	$50,000,000	$41,400,000	$20,800,000	$70,000,000	$15,000,000
Alabama	3,983,959	484,208	981,493	375,277	1,781,083	361,898
Alaska	1,200,000	300,000	300,000	300,000	200,000	100,000
Arizona	1,917,355	300,000	413,822	300,000	750,948	152,585
Arkansas	2,438,601	323,697	570,116	300,000	1,034,573	210,215
California	11,935,223	2,296,326	2,703,196	1,033,575	4,905,398	996,728
Colorado	2,208,632	504,054	441,221	300,000	800,669	162,688
Connecticut	2,105,525	784,632	320,694	300,000	581,952	118,247
Delaware	1,200,000	300,000	300,000	300,000	200,000	100,000
Dist. of Col.	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida	6,630,626	1,245,145	1,510,340	577,483	2,740,762	556,896
Georgia	4,551,507	707,966	1,077,908	412,142	1,956,043	397,448
Hawaii	1,200,000	300,000	300,000	300,000	200,000	100,000
Idaho	1,333,485	300,000	300,000	300,000	333,485	100,000
Illinois	7,335,450	2,321,146	1,406,245	537,682	2,551,864	518,513
Indiana	4,720,542	1,304,592	957,991	366,291	1,738,435	353,233
Iowa	3,032,839	963,066	555,940	300,000	1,008,846	204,987
Kansas	2,313,685	753,384	395,899	300,000	718,425	145,977
Kentucky	3,564,731	544,077	847,132	323,904	1,537,262	312,356
Louisiana	4,452,304	995,065	969,571	370,719	1,759,447	357,502
Maine	1,475,739	325,198	300,000	300,000	450,541	100,000
Maryland	2,569,667	401,113	586,970	300,000	1,065,155	216,429
Massachusetts	4,796,378	1,894,134	813,925	311,206	1,477,001	300,112
Michigan	6,436,724	1,644,663	1,343,917	513,851	2,438,761	495,532
Minnesota	3,637,732	1,083,790	708,032	300,000	1,284,843	261,067
Mississippi	2,913,642	357,995	708,568	300,000	1,285,814	261,265

Missouri	4,618,643	1,356,532	914,848	349,795	1,660,143	337,325
Montana	1,288,826	300,000	300,000	300,000	288,826	100,000
Nebraska	1,518,181	300,000	300,000	300,000	513,785	104,396
Nevada	1,200,000	300,000	300,000	300,000	200,000	100,000
New Hampshire	1,289,381	300,000	300,000	300,000	289,381	100,000
New Jersey	5,860,709	2,664,549	896,352	342,723	1,626,580	330,505
New Mexico	1,510,672	300,000	300,000	300,000	507,544	103,128
New York	11,877,535	4,766,160	1,994,361	762,550	3,619,099	735,365
North Carolina	5,800,820	1,261,661	1,272,992	486,733	2,310,054	469,380
North Dakota	1,281,129	300,000	300,000	300,000	281,129	100,000
Ohio	7,988,504	1,598,636	1,792,017	685,183	3,251,912	660,756
Oklahoma	2,921,303	663,580	614,981	300,000	1,115,985	226,757
Oregon	2,044,559	398,251	422,917	300,000	767,452	155,939
Pennsylvania	11,266,612	3,929,588	2,057,644	786,746	3,733,936	758,698
Rhode Island	1,306,717	300,000	300,000	300,000	306,717	100,000
South Carolina	3,212,299	558,481	739,407	300,000	1,341,776	272,635
South Dakota	1,301,794	300,000	300,000	300,000	301,794	100,000
Tennessee	4,744,019	1,000,086	1,049,973	401,461	1,905,351	387,148
Texas	11,554,949	2,792,217	2,457,479	939,624	4,459,503	906,126
Utah	1,509,003	300,000	300,000	300,000	506,157	102,846
Vermont	1,200,000	300,000	300,000	300,000	200,000	100,000
Virginia	4,468,550	1,045,785	959,903	367,022	1,741,903	353,937
Washington	2,676,249	571,806	566,831	300,000	1,028,609	209,003
West Virginia	2,532,299	736,117	469,997	300,000	852,887	173,298
Wisconsin	3,994,823	855,621	880,379	336,615	1,597,593	324,615
Wyoming	1,200,000	300,000	300,000	300,000	200,000	100,000
American Samoa	750,000	200,000	200,000	200,000	100,000	50,000
Guam	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico	4,878,078	966,679	1,096,939	419,418	1,990,577	404,465
Trust Territory	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands	750,000	200,000	200,000	200,000	100,000	50,000

FISCAL YEAR 1974 GRANT ALLOCATIONS TO STATES
FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES

States	Total	Modernization	Hospitals and Public Health Centers	Long-Term Care Facilities	Outpatient Facilities	Rehabilitation Facilities
Total	$185,440,000	$47,500,000	$37,430,000	$19,760,000	$66,500,000	$14,250,000
Alabama	3,697,003	456,758	871,309	337,809	1,689,678	341,449
Alaska	1,200,000	300,000	300,000	300,000	200,000	100,000
Arizona	1,823,737	300,000	367,365	300,000	712,409	143,963
Arkansas	2,291,278	305,346	506,115	300,000	981,480	198,337
California	11,090,322	2,166,149	2,399,729	930,382	4,653,655	940,407
Colorado	2,080,243	475,480	391,689	300,000	759,579	153,495
Connecticut	2,003,803	740,152	300,000	300,000	552,086	111,565
Delaware	1,200,000	300,000	300,000	300,000	200,000	100,000
Dist. of Col.	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida	6,160,708	1,174,559	1,340,786	519,827	2,600,108	525,428
Georgia	4,226,374	667,832	956,900	370,992	1,855,659	374,991
Hawaii	1,200,000	300,000	300,000	300,000	200,000	100,000
Idaho	1,316,370	300,000	300,000	300,000	316,370	100,000
Illinois	6,832,057	2,189,562	1,248,377	483,999	2,420,904	489,215
Indiana	4,393,293	1,230,635	850,446	329,720	1,649,219	333,273
Iowa	2,852,476	908,471	493,529	300,000	957,072	193,404
Kansas	2,181,413	710,675	351,455	300,000	681,555	137,728
Kentucky	3,318,342	513,233	752,031	300,000	1,458,371	294,707
Louisiana	4,139,541	938,656	860,725	333,706	1,669,153	337,301
Maine	1,434,181	306,762	300,000	300,000	427,419	100,000
Maryland	2,414,141	378,374	521,076	300,000	1,010,491	204,200
Massachusetts	4,493,664	1,786,756	722,552	300,000	1,401,202	283,154
Michigan	5,938,158	1,551,428	1,193,046	462,548	2,313,604	467,532
Minnesota	3,416,119	1,022,350	628,548	300,000	1,218,905	246,316
Mississippi	2,733,049	337,700	629,022	300,000	1,219,826	246,501

MIssouri	4,299,857	1,279,631	812,145	314,871	1,574,946	318,264
Montana	1,274,003	300,000	300,000	300,000	274,003	100,000
Nebraska	1,487,418	300,000	300,000	300,000	487,418	100,000
Nevada	1,200,000	300,000	300,000	300,000	200,000	100,000
New Hampshire	1,274,530	300,000	300,000	300,000	274,530	100,000
New Jersey	5,472,665	2,513,498	795,726	308,506	1,543,105	311,830
New Mexico	1,481,497	300,000	300,000	300,000	481,497	100,000
New York	11,080,035	4,495,969	1,770,469	686,416	3,433,368	693,813
North Carolina	5,392,718	1,190,138	1,130,083	438,136	2,191,503	442,858
North Dakota	1,266,701	300,000	300,000	300,000	266,701	100,000
Ohio	7,424,070	1,508,010	1,590,841	616,773	3,085,025	623,421
Oklahoma	2,744,563	625,963	545,942	300,000	1,058,714	213,944
Oregon	1,926,310	375,675	375,439	300,000	728,068	147,128
Pennsylvania	10,499,806	3,706,822	1,826,648	708,197	3,542,311	715,828
Rhode Island	1,290,977	300,000	300,000	300,000	290,977	100,000
South Carolina	3,013,366	526,821	656,399	300,000	1,272,916	257,230
South Dakota	1,286,306	300,000	300,000	300,000	286,306	100,000
Tennessee	4,409,712	943,392	932,101	361,378	1,807,569	365,272
Texas	10,746,903	2,633,928	2,181,595	845,811	4,230,643	854,926
Utah	1,480,181	300,000	300,000	300,000	480,181	100,000
Vermont	1,200,000	300,000	300,000	300,000	200,000	100,000
Virginia	4,155,467	986,501	852,142	330,378	1,652,508	333,938
Washington	2,515,603	539,391	503,197	300,000	975,822	197,193
West Virginia	2,384,244	694,388	417,234	300,000	809,116	163,506
Wisconsin	3,713,547	807,116	781,545	303,008	1,515,606	306,272
Wyoming	1,200,000	300,000	300,000	300,000	200,000	100,000
American Samoa	750,000	200,000	200,000	200,000	100,000	50,000
Guam	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico	4,533,249	911,879	973,794	377,543	1,888,422	381,611
Trust Territory	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands	750,000	200,000	200,000	200,000	100,000	50,000

HEALTH SERVICES RESEARCH

Mr. CONTE. Dr. Endicott, what is the status of your proposal to eliminate the 25-percent intramural requirement for health services research? How hard are you pushing for that repeal?

Dr. ENDICOTT. In February of this year, the Department submitted to the House legislative language which would amend Public Law 93–353 as part of a bill entitled "Health Services Amendments of 1975". This language requested repeal of the 25-percent intramural research authority. We understand that the Congress did not consider this repeal language, and thus the 25-percent earmarking is still in effect.

Constraints posed by the recruitment process and by position limitations in the Department would make it impossible for the National Center for Health Services Research to implement the 25-percent requirement in the first year. We continue to recommend that the Congress consider the amendment.

Mr. CONTE. Can you explain why you have a nearly $10 million decrease in research grants and contracts scheduled for 1976?

Dr. ENDICOTT. The reduction in the budget for 1976 compared with 1975 was based on the Department's legislative proposal to delete the specific intramural research level which is mandated in the enabling legislation. We have been assured by the administration that there was no attempt to avoid the conduct of much-needed research but rather a desire to get away from percentage goals.

The Department proposed a legislative amendment to the Congress which would have repealed the 25-percent intramural requirement. The Congress, however, has not considered the repeal language and the 25-percent requirement is still in effect.

DISTRICT OF COLUMBIA MEDICAL DENTAL SCHOOL AWARDS

Mr. CONTE. Your justification states that the District of Columbia medical/dental schools awards are not needed because these schools can compete with other schools for funds under other health manpower programs. Can you tell me what those other manpower programs are?

Dr. ENDICOTT. Yes, sir. These schools are eligible to participate in the health professions capitation program and to compete for special project and financial distress grants. These schools are expected to apply and they will receive equal consideration.

HEALTH MANPOWER STUDENT LOANS

Mr. CONTE. Your justification indicates that you will be depending on an expanded guaranteed student loan program for health manpower support. Can you tell me the amount that the program is being expanded, and relate that amount to your proposed phaseout?

Dr. ENDICOTT. Secretary Weinberger before a House subcommittee on February 20, recommended that the total existing loan ceiling be increased from $10,000 to $25,000 and the annual ceiling also be increased from $2,500 to $7,000. The maximum annual health professions loan amount is $3,500 and a scholarship $3,500 which together equal the recommended new annual ceiling.

REDUCTIONS IN INSTITUTIONAL ASSISTANCE

Mr. CONTE. You have a fairly large cut proposed in health professions support through institutional assistance. Would you please give me all the arguments, and elaborate in the record if you want to, on why we should reduce the level of institution support? Can you provide hard evidence that either we no longer have health manpower needs, or that there actually are alternative means of support for this?

Dr. ENDICOTT. The Federal Government continues to provide substantial support to health professions institutions. However, we have attempted to reduce what we feel are unnecessary subsidies. For example, capitation is merely one source of revenue to a school. Student tuition is another. We feel that reductions in capitation levels would not be as seriously felt if students were asked to assume a larger direct share of the costs of their own education. Further, a number of undergraduate professional schools are responsive to local needs and therefore should, if necessary, be funded with local resources.

Mr. CONTE. That is all.

Mr. FLOOD. Mr. Stokes.

MEDICAL CONSUMER ORGANIZATIONS

Mr. STOKES. How do medical consumer organizations gain access to information about your programs?

Dr. ENDICOTT. The Office of Health Resources Opportunity through the support of discretionary programs funds organizations such as: National Chicano Health Organization, the National Medical Association, National Indian Health Organization, National Puerto Rican Organization, National Consumer Health Organization, national organizations that support low-income whites and others. These organizations work with their constituents in improving access to health services and health careers to the disadvantaged population.

COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971

Mr. STOKES. How much money and how many grants were awarded under section 774(b) of the Comprehensive Health Manpower Training Act of 1971 in fiscal years 1974 and 1975?

Dr. ENDICOTT. In fiscal year 1974, the program entitled "Special Health Career Opportunity Grant" received $6,975,000 plus $1,300,000 from the fiscal year 1973 impoundment release and awarded 65 grants across the Nation. In fiscal year 1975, the program received $6,686,000, as authorized by the continuing resolution, and it is estimated that 63 grants will be awarded.

Mr. STOKES. What type of support does this program provide?

Dr. ENDICOTT. The program provides support to health and/or educational entities that design programs which motivate, recruit, prepare and retain socioeconomic and educationally disadvantaged students interested in pursuing a health career. In addition to administrative cost, the program provides a very limited amount of financial assistance to students participating in preparatory, remediation or reinforcement type of programs.

Mr. STOKES. How many students have benefited from the program since its beginning?

Dr. ENDICOTT. It is estimated that approximately 9,000 students have benefited directly since fiscal year 1972. There are, however, some grants in which the definite number of students is undetermined since the grants deal with dissemination of information and motivation. Such programs as the National Chicano Health Organiztion Grant, the National Medical Association Foundation, Odwin-Health Careers, Inc., Aspira of America, the Cheyenne and Arapaho Health Education Committee and others.

It is estimated that in fiscal year 1975, approximately 4,000 students will benefit.

Mr. STOKES. What educational levels are targeted by this program?

Dr. ENDICOTT. The program encompasses from the secondary level (high school) to health professional (graduate) level. The largest percentage of grants cover the senior high school level and the undergraduate level.

Mr. STOKES. What are your future program plans in this area?

Dr. ENDICOTT. Depending on legislation we propose to continue present efforts emphasizing the recruitment and retention of disadvantaged students at the undergraduate and health professional school levels, and to expand the program to provide financial assistance to disadvantaged students. The administration's bill and the Beall substitute bill considered by the 93d Congress proposed an unconditional scholarship authorization for disadvantaged students.

DEFINITION OF "SOCIOECONOMIC AND DISADVANTAGED INDIVIDUALS"

Mr. STOKES. What is the functional definition of socioeconomic and disadvantaged individuals?

Dr. ENDICOTT. "Disadvantaged" can be broadly characterized as comprised of two groups: (1) those who face inequity in access to optimal medical care; (2) those who face inequity in access to health career opportunities for operational purposes within OHRO; however, "disadvantaged" must be precisely distinguished through a constellation of factors such as race, sex, age, economic status, formal education and geographic residence. For the purpose of OHRO these factors can be translated into being black, native American, Asian American or, Spanish surnamed, being a woman, being elderly, being poor, having inadequate schooling or training, or residing in rural areas or inner cities.

ALLIED HEALTH PROFESSIONS

Mr. STOKES. I understand that in the same act of 1971, section 794A parallels section 774(b), but it's specifically directed to the allied health professions. What kinds of activities have you supported in this area? What are your future plans in this area?

Dr. ENDICOTT. Section 794A of this PHS Act is directed to encourage full utilization of educational talent for the allied health professions. We are supporting efforts for three regional studies to identify barriers limiting entry of minority students into the allied health professions. We are developing a prototype allied health counseling model for high school and college level counselors that will assist counselors in providing career counseling for socioeconomic disadvantaged stu-

dents through educational program guidance and financial aid information. We are also supporting the development of counseling programs for implementation in existing secondary school systems. These will be directed to serve socioeconomic disadvantaged students. These initial programs are experimental and are designed to bring students into health careers by introducing the student to available careers when the student first enters the secondary education level.

The 1976 budget request does not contain funds for the continuation of these allied health programs. Such workers are basically a local resource, and the administration feels that the States and local governments should assume full support for this kind of training.

NURSE TRAINING ACT OF 1971

Mr. STOKES. The Nurse Training Act of 1971 also authorized a similar section for the disadvantaged; what activities have been supported by this section? What type of program activity is involved?

Dr. ENDICOTT. The Nurse Training Act of 1971 broadened the original authority which provided for an active nursing education recruitment program, with emphasis on attracting disadvantaged and minority students to provide for upward mobility in nursing through recruitment of licensed practical nurses, ex-medical corpsmen, and others who desire to become registered nurses.

Significant progress has been made toward achieving the objectives of the legislation. The inner-city high school student, graduate, and dropout has been reached, and "talent" has been identified and encouraged to enroll in educational programs that will help students eventually realize careers in nursing. The contracts have provided motivation and assistance for potential nursing candidates to: (1) Stay in school and take prerequisites for nursing school admission; (2) enroll in prenursing courses, remedial programs; and (3) complete necessary applications forms in order to be admitted, receive financial aid and supportive services in the school of the candidate's choice, in line with his potential and career goal.

Mr. STOKES. How may students have been benefited from this program?

Dr. ENDICOTT. Over a 6-year period, we estimate that approximately 25,000 young people have received information about nursing as a career, and of these, 2,500 have entered schools of nursing.

Mr. STOKES. What are your future program plans in this area?

Dr. ENDICOTT. The legislation now before Congress broadens the previous authority for disadvantaged students, and it will be a part of the special project grant and contract authority with 10 percent of the appropriated funds earmarked for disadvantaged students.

COMPARISON OF FISCAL YEARS 1975 AND 1976 BUDGET REQUESTS

Mr. STOKES. How does the 1976 request for SHCOG's compare to prior years?

Dr. ENDICOTT. In fiscal year 1972, the SHCOG program received $5 million which funded 42 grants; in fiscal year 1973, the program received $5 million, which funded 48 grants; fiscal year 1974, the program received $7,269,336 to fund 65 grants. In fiscal year 1975, the program received $6,686,000, and approximately 63 grants will be

funded. The SHCOG program has requested in fiscal year 1976 $9,686,000 which constitutes an increase of $3 million which will be spent to fund new grants and implement the student assistance program proposed in legislation.

Mr. STOKES. What additional funds are at the disposal of the Office of Health Resources Opportunity (OHRO), and for what purpose?

Dr. ENDICOTT. The Office of Health Resources Opportunity, in addition to the SHCOG program funds, has limited direct operations moneys to fund contracts in three basic areas:

1. The areas of health manpower training models.
2. Health services models.
3. Research and evaluation projects.

Mr. STOKES. Can resources be reallocated to establish OHRO as a program entity without major modification in the total mission of HRA?

Dr. ENDICOTT. The Office of Health Resources Opportunity is already an established office within the mission of the Health Resources Administration. Modifications regarding the establishment of a line-item budget and signoff already on all HRA programs are currently being considered.

OHRO ABSORPTION OF HRA ACTIVITIES

Mr. STOKES. Identify other HRA activities that potentially could be absorbed by or grafted onto the OHRO operation. Discuss the technical and other problems associated with these changes.

Dr. ENDICOTT. There are other HRA activities that are under consideration, but a decision is delayed until a further in-depth analysis can be made.

HEALTH PROFESSIONS

Mr. STOKES. How much funding support for stipend assistance and scholarship support in the first year of professional training are you planning to allocate for the disadvantaged students in fiscal year 1976?

Dr. ENDICOTT. In fiscal year 1976, if the legislative authority approves the scholarship program for disadvantaged students, there will be support for these students during the first year of their professional training. It is estimated that $2 million will be made available to 400 disadvantaged students at a maximum of $5,000 per year, per student.

Mr. STOKES. We have information that your health professions grants for the educationally deprived are decentralized to the regions. How much central office direction and overview is exercised to insure that the eligible people as stipulated on the law are being supported?

Dr. ENDICOTT. The Office of Health Resources Opportunity has central office responsibility for the SHCOG program which is currently decentralized to the 10 DHEW regions. The Office responsibility lies in developing program policy, establishing program priorities, developing and assisting the regional offices in administrative procedures for monitoring programs, allocating funds to the regional offices and developing national reports on the SHCOG program. Daily communication has been established by this program and the 10 DHEW regional offices.

ALLIED HEALTH

Mr. STOKES. Why have you not requested funds for training for the deprived under section 794A?

Dr. ENDICOTT. The administration considers members of the allied health professions as a local resource and thus feels the States and local governments should assume the full support for training this profession.

Mr. STOKES. Does administration plan to support new legislation for this program?

Dr. ENDICOTT. Yes, sir, but under a broad general authority which provides more flexible approaches to assist individuals in secondary schools and postsecondary educational training in the allied health professions.

Dr. STOKES. Does administration plan to support new legislation for this program?

Dr. ENDICOTT. Yes, sir, but under a broad general authority which provides more flexible approaches to assist individuals in secondary schools and postsecondary educational training in the allied health professions.

Mr. STOKES. Do you feel that the Federal Government should push for the educational deprived to go into allied health professions?

Dr. ENDICOTT. The allied health field can provide good opportunities for the educationally deprived to achieve rewarding careers. The Department is heavily involved in projects to insure that employment opportunities in these occupations are improved, by working toward more relevant, objective, and nondiscriminatory methods of credentialing.

Mr. STOKES. What type of project activity in allied health was specifically supported by the $200,000 that has been obligated in the past 3 years? Did this money specifically go to support the targeted population as identified in section 794A of the old law and is still in effect under continuing resolution for fiscal year 1975?

Dr. ENDICOTT. Yes, sir, the money was used to support the targeted populations identified in the law. We supported projects identifying barriers limiting entry of minority students into the allied health professions and projects assisting counselors in providing career counseling for socioeconomic disadvantaged students.

NURSING

Mr. STOKES. I see that the level of obligation has been higher in the past 3 years for full utilization of education talent in nursing as authorized in Public Law 92–158, section 868. Can you state that these obligations have been used to directly support the targeted populations sectors called for in the law?

Dr. ENDICOTT. Awards under this authority are made to schools of nursing and other nursing organizations. As I previously stated, these funds are being used to support the inner-city high school student, graduate, and dropout. For example, a contract with the National Student Nurses' Association, "Breakthrough to Nursing," has yielded results and highlighted problems in minority recruitment. Since this nationwide project received this assistance, it has enrolled 500 minority students in schools of nursing. Four hundred student nurse volunteers, many from minority groups, are working in 39 States publicizing nursing opportunities, identifying and motivating potential recruits, helping students to remain in school until graduation, and locating black, Chicano, and Indian American registered nurses to serve as role models for aspiring minority students.

Mr. STOKES. Can you be specific in identifying the population sectors which have been supported by this section?

Dr. ENDICOTT. Yes, sir; we have supported black, Indian American, Chicano, and rural Appalachia population sectors.

Mr. STOKES. I understand that the nursing programs are decentralized to the DHEW regions. What type of supervision or monitoring is in place from your Central Office here in Washington to assure that this nursing program is supporting people who are eligible under this program?

Dr. ENDICOTT. This was not one of the programs that was decentralized. Contracts were developed and supervised from the Central Office and were intended to increase opportunities for population sectors underrepresented in nursing.

EXPANSION OF OHRO

Mr. STOKES. If this expansion is proposed for the OHRO component, what items would have the highest priorities and why?

Dr. ENDICOTT. We view the continuing and increased viability of the Office of Health Resources Opportunity as an important program necessity within the agency to raise awareness and sensitivity levels to the health needs of racial, ethnic minorities, the economically poor, and women. The Office of Health Resources Opportunity staff has my full support to participate in all initial and forward planning activities for current and future program operations. The highest priorities of need at this time are for program development to give special focus on the needs of American Indians and Hispanics.

Mr. STOKES. What is involved in a major effort to build up OHRO capacity—dollars, people, technical assistance, and training?

Dr. ENDICOTT. The efforts to increase the capacity of the Health Resources Administration are now in a planning stage and the manpower and financial resources levels have not yet been determined. However, we are moving ahead to secure representatives from the Native American and Hispanic communities with the necessary technical skills and commitment to help develop and implement innovative health models and demonstrations of these community sectors.

HEALTH PROFESSIONS

Mr. STOKES. I am told that there are large numbers of organizations seeking assistance under the health professions section of the law. How much support do you expect to be obligated in fiscal year 1975 and beyond—when the new legislation is passed?

Dr. ENDICOTT. Operating as we are under the continuing resolution in 1975, we will be obligating an estimated $249,350,000 for health professions. Because the authorizing legislation for health manpower has yet to be enacted, I cannot furnish you a definitive answer as to how much will be obligated in 1976 and beyond. Our 1976 budget, which contains $168,942,000 for health professions, was developed to support the administration's proposed health manpower legislation.

Mr. STOKES. Thank you very much.

Mr. FLOOD. Thank you, Dr. Endicott.

Dr. ENDICOTT. Thank you. Mr. Chairman.

Justification of the Budget Estimates

Appropriation Estimate

HEALTH RESOURCES

For carrying out [the District of Columbia Medical and Dental Manpower Act of 1970, as amended, $7,500,000][1] *to the extent not otherwise provided, section 225, titles III, VII, VIII, XV, and XVI of the Public Health Service Act, section 1122 of the Social Security Act and section 222 of the Social Security Amendments of 1972, $611,487,000 of which $3,000,000 shall be available for loan guarantees and interest subsidies under part B of title VII and part A of title VIII and shall remain available until expended and not to exceed $100,000,000 for title XVI shall remain available through September 30, 1978: Provided, That, in addition, $42,000 may be transferred to this appropriation, as authorized by section 201(g) of the Social Security Act from any one or all of the trust funds referred to therein.*[2]

[For carrying out, to the extent not otherwise provided, section 225, titles III, VII, and VIII, of the Public Health Service Act, section 222 of the Social Security Amendments of 1972, $147,933,000: *Provided,* That in addition, $120,000 may be transferred to this appropriation, as authorized by section 201(g) of the Social Security Act from any one or all of the trust funds referred to therein.][3]

[Loans, grants, and payments for the next succeeding fiscal year: For making, after December 31 of the current fiscal year, loans, grants, and payments under section 225, part C of title VII, and part B of title VIII of the Public Health Service Act for the first quarter of the next succeeding fiscal year, such sums as may be necessary, and obligations incurred and expenditures made hereunder shall be charged to the appropriation for that

purpose for such fiscal year: *Provided*, That such loans, grants, and payments pursuant to this paragraph may not exceed 50 per centum of the amounts authorized in part C of title VII, and in part B of title VIII for these purposes for the next succeeding fiscal year.][4]

Explanation of Language Changes

1. Language has been deleted which specifically appropriated funds under a program which is proposed to be unfunded in 1976.

2. Part of the language added incorporates references to programs funded under the Supplemental Appropriations Act, 1975; part incorporates references to programs to carry out titles XV and XVI of the Public Health Service Act and section 1122 of the Social Security Act which have been submitted in a second supplemental request for 1975; part earmarks funds for loan guarantees and interest subsidies related to construction of teaching facilities projects awarded in prior years; and part earmarks funds for construction allotments, loans, loan guarantees, and interest subsidies under title XVI to remain available through 1978 as authorized in the basic law.

3. Reference to the basic law has been simplified.

4. This deletes authority for advance obligation of funds for certain student assistance programs. There is no authorizing legislation for this provision.

Analysis of Appropriation Language

Language Provision	Explanation
"...of which $3,000,000 shall be available for loan guarantees and interest subsidies under part B of title VII and part A of title VIII and shall remain available until expended..."	This provision specifies an amount left unspecified by the authorizing legislation, which permits these funds to remain available to the Secretary without fiscal year limitation.
"...not to exceed $100,000,000 for title XVI shall remain available through September 30, 1978..."	This provision specifies a lower ceiling within the maximum amount of $130,000,000 specified by the authorizing legislation which permits funds to be allotted to States and to remain available for the next two fiscal years.
"...provided, that, in addition, $42,000 may be transferred to this appropriation, as authorized by section 201(g) of the Social Security Act from any one or all of the trust funds referred to therein..."	This provision specifies an amount which may be transferred from Social Security trust funds as authorized by the Social Security Act.

Appropriation Estimate

HEALTH RESOURCES

For "Health resources" for the period July 1, 1976, through September 30, 1976, $135,290,000, of which $3,000,000 shall be available for loan guarantees and interest subsidies under part B of title VII and part A of title VIII and shall remain available until expended: Provided, That in addition, $11,000 may be transferred to this appropriation, as authorized by section 201(g) of the Social Security Act from any one or all of the trust funds referred to therein.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Amounts Available for Obligation 1/

	1975 Revised	1976
Appropriation	$155,433,000	$611,487,000
Proposed supplemental	66,500,000	---
Continuing resolution authority	609,812,000	---
subtotal, adjusted appropriation	831,745,000	611,487,000
Comparative transfers to:		
"Health Services Administration" of the Emergency Medical Services program management	-984,000	---
"Health Services Administration", "Alcohol, Drug Abuse and Mental Health Administration","Public Health Service Service and Supply Fund", and "Office of the Assistant Secretary for Health" of 13 upward mobility positions	-216,000	---
"Departmental Management, Office of the Secretary" 3 positions for establishment of Office of Assistant Regional Director for Public Affairs for each region	-81,000	---
"Office of the Assistant Secretary for Health" for cost of the automated terminal system	-14,000	---
"Departmental Management, Office of the Secretary" for cost of OS audiovisual management information system	-2,000	---
Comparative transfers from:		
"Assistant Secretary for Health" for 39 regional Comprehensive Health Planning personnel	+824,000	---
"Health Services Administration" for costs of production of health services reports	+54,000	---
Subtotal, budget authority	831,326,000	611,487,000
Receipts and reimbursements from: "Social Security Trust Fund"	8,620,000	42,000
Comparative transfer to: "Department Management, Office of the Secretary" for training of Long-Term Care personnel in the regional offices	-78,000	---
Unobligated balance, start of year	353,574,000	135,936,000
Unobligated balance, end of year	-135,936,000	-96,670,000
Total, obligations	1,057,506,000	650,795,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1975 revised - $1,010,000; 1976 - $1,010,000.

Summary of Changes

1975 Estimated Obligations	$1,057,506,000
1976 Estimated Obligations	650,795,000
Net Change	-406,711,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Annualization of 150 positions new in 1975	---	---	---	+$2,856,000
2. Within-grade pay increases	---	---	---	+602,000
3. FTS, postage & telephone increases	---	---	---	+96,000
4. One additional day of pay	---	---	---	+329,000
5. Office of Federal employee Compensation costs increase	---	---	---	+10,000
6. Increased unit costs for reimbursable contracts with the Bureau of Census	---	---	---	+46,000
7. Annualization of pay increases	---	---	---	+561,000
8. Increased costs for the service & supply fund	---	---	---	+73,000
9. Payment to GSA for building space rent as required by the Public Buildings Amendments of 1972 (P.L. 92-313)	---	---	---	+500,000
10. Increase payments to Working Capital Fund	---	---	---	+39,000
11. NIH Management Fund increase	---	---	---	+6,000
Subtotal	---	---	---	+5,118,000
B. Program:				
(National Health Statistics)				
1. Continued development of the Cooperative Health Statistics System & preliminary work to develop capability to collect and analyze data on health economics	---	3,708,000	---	+3,315,000
(Health services research)				
2. Intramural research	18	1,000,000	---	+2,900,000
(Health Planning & Resources Development)				
3. Planning & resources development	---	18,700,000	---	+43,300,000
4. Construction grants	---	85,659,000	---	+53,607,000
(Health Manpower)				
(Health Professions)				
5. Student assistance:				
a. Loan repayments	---	3,000,000	---	+3,000,000
(Nursing)				
6. Student assistance:				
a. Loan repayments	---	100,000	---	+2,400,000
(Special Educational Programs)				
7. Health professions special projects	---	37,583,000	---	+7,889,000
8. Family medicine residencies	---	9,500,000	---	+17,500,000
9. Primary care residencies	---	---	---	+12,000,000
10. Physicians assistants	---	8,000,000	---	+4,000,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
11. Area health educational centers and other initiatives	---	12,000,000	---	+4,000,000
12. Manpower initiatives	---	11,189,000	---	+3,211,000
13. Special health career opportunity grants	---	6,686,000	---	+3,000,000
(Health Facilities Construction) (Health Teaching Facilities)				
14. Interest Subsidies	---	300,000	---	+2,700,000
Subtotal	---	---	---	+162,822,000
Total, increases	---	---	---	+167,940,000
Decreases:				
A. Built-in:				
1. Non-recurring equipment costs (program management)	---	---	---	-231,000
2. Non-recurring project contracts completed (program management)	---	---	---	-1,537,000
3. Non-competing projects completed or converted to competing status(HSR)	---	---	---	-11,705,000
Subtotal	---	---	---	-13,473,000
B. Program:				
(Health Planning and Resources Development)				
1. Transition costs	---	109,139,000	---	-109,139,000
2. Capital expenditure reviews	---	7,956,000	---	-3,956,000
(Health Services Research)				
3. Research grants and contracts: research training projects	---	2,000,000	---	-1,100,000
4. Emergency medical services systems training activities	---	6,667,000	---	-6,667,000
(Health Manpower) (Health Professions)				
5. Institutional assistance:				
a. Capitation	---	150,000,000	---	-48,900,000
b. Start-up and conversion	---	4,700,000	---	-1,700,000
c. Financial distress	---	12,954,000	---	-7,954,000
d. D.C. medical/dental schools	---	7,500,000	---	-7,500,000
6. Student assistance:				
a. Loans	---	33,954,000	---	-13,954,000
b. Scholarships	---	6,900,000	---	-3,400,000
(Nursing)				
7. Institutional assistance:				
a. Capitation	---	34,343,000	---	-34,343,000
b. Financial distress	---	4,750,000	---	-4,750,000
8. Student assistance:				
a. Loans	---	22,800,000	---	-13,800,000
b. Scholarships	---	6,000,000	---	-2,000,000
c. Traineeships	---	13,016,000	---	-13,016,000
9. Public health	---	20,520,000	---	-20,520,000
10. Allied health	---	33,821,000	---	-33,821,000
(Special Educational Programs)				
11. Nursing special projects	---	19,000,000	---	-1,000,000
12. Physician opportunity	---	600,000	---	-600,000

	Base		Change from Base	
	Pos.	Amounts	Pos.	Amounts
(Health Facilities Construction) (Health Teaching Facilities) 13. Construction grants	---	233,058,000	---	-233,058,000
Subtotal	---	---	---	-561,178,000
Total, decreases	---	---	---	-574,651,000
Total, net change	---	---	---	-406,711,000

Explanation of Changes

Increases:

A. Built-in:

Of the $5,118,000 requested for built-in increases, a total of $324,000 is related to operations of the National Center for Health Statistics; and $4,794,000 is for the operational activities of program management.

B. Program:

(National Health Statistics)

1. The increase of $3,315,000 will continue the development of the Cooperative Health Statistics System by funding the Federal share of State data collection systems, supporting developmental projects undertaken by the States, and providing technical assistance to the States.

(Health Services Research)

2. Intramural research -- The increase of $2,900,000 will support intramural research staff and studies.

(Health Planning and Resources Development)

3. Planning and resources development -- The increase of $43,300,000 will fund the new State and local agencies in 1976.

4. Construction grants -- Of the increase of $53,607,000, $43,607,000 is applicable to the 1973 and 1974 appropriations and $10,000,000 is against the 1976 appropriation request.

(Health Manpower)

5. Health professions student assistance:

a. Loan repayments--An increase of $3,000,000 is requested to support approximately 650 additional applications anticipated for this program in 1976.

6. Nursing student assistance:

a. Loan repayments--The requested increase of $2,400,000 will bring the total funds available to $2,500,000 in 1976 to repay an estimated 960 loans.

Special Educational Programs

7. Health professions special projects--The requested increase of $7,889,000 would support 29 new grants and 6 new project contracts to correct problems of specialty and geographic maldistribution.

8. Family medicine residencies--The increase of $17,500,000 would provide a total program level of $27,000,000 which would support approximately 165 projects; 73 continuation projects and 92 new projects providing training to approximately 3,000 students.

9. Primary care residencies--The request of $12,000,000 will support 48 new projects offering 290 residency years of instructions.

10. Physicians assistants--The increase of $4,000,000 would fund approximately 23 new programs training 3,100 students.

11. AHECs and other initiatives--The requested increase of $4,000,000 would support the continuation and expand the scope of the Area Health Education Center contracts initiated in 1972.

12. Manpower initiatives--The requested increase of $3,211,000 will provide continuation support for eight and initiate 20 new projects including the team approach to delivery of primary health care and recruitment and retention of the disadvantaged in health careers.

13. Special health career opportunity grants--The increase of $3,000,000 will support four new projects directed toward motivating, recruiting and retaining students in the various health professions.

(Health Facilities Construction)

14. Health teaching facilities interest subsidies--The requested increase of $2,700,000 is the amount that is needed in 1976 to reduce the net effective interest rate by up to three percent which would be paid by the government, on behalf of the health professions schools, to lending institutions. This represents interest for a principal amount of $198,000,000.

Decreases:

A. Built-in:

Of the $13,473,000 built-in decreases reflected, a total of $1,768,000 is related to non-recurring equipment costs, and project contracts in program management; and $11,705,000 for non-competing projects completed or converted to competing status in the health services research extramural program.

B. Program:

(Health Planning and Resources Development)

1. Transition costs--The decrease of $109,139,000 reflects the request for no transition funds in 1976. The transition agencies have received the necessary phase-out funding in 1975.

2. Capital expenditure reviews--The $3,956,000 decrease in capital expenditure reviews reflects the implementation of the new health planning legislation, whereby grants to the new local and State agencies will fund capital expenditure reviews activities.

(Health Services Research)

3. Research training--The decrease of $1,100,000 represents the completion of 29 projects.

4. Emergency medical services systems training projects--The decrease of $6,667,000 represents the obligation in 1975 of a one-time appropriation in 1974 and available for obligation through September 30, 1974. Seventy-six projects were funded in 1975.

(Health Manpower)

5. Health professions institutional assistance:

a. Capitation--The requested decrease of $48,900,000 represents a gradual phase-down of this program in accordance with the proposed statutory student capitation rate.

b. Start-up and conversion--A decrease of $1,700,000 is requested since no conversion applications are expected in 1976 and funds will be required only for continuation of five start-up grants.

c. Financial distress--The requested decrease of $7,954,000 reflects efforts of this program to encourage schools to attain financial independence and stability after receiving initial financial distress assistance. This represents obligations in 1975 against funds appropriated in 1974.

d. D.C. medical/dental schools--The decrease of $7,500,000 represents obligations in 1975 of a one-time appropriation for aid to the George Washington medical school and Georgetown medical and dental schools.

6. Health professions student assistance:

a. Loans--The requested decrease of $13,954,000 reflects the intention to gradually phase out this program in favor of a general guaranteed loan program.

b. Scholarships--The requested decrease of $3,400,000 reflects the intention to gradually phase out this program in favor of other scholarship programs which require a commitment on the part of students to serve in the public interest. Support is to be provided to 4,057 students who have received prior assistance.

7. Nursing institutional assistance:

a. Capitation--The decrease of $34,343,000 reflects the termination of the nurse capitation program. It is felt that the current training capacity of nursing schools is adequate to meet the Nation's needs.

b. Financial distress--The requested decrease of $4,750,000 reflects the intention to phase out this program. Financial distress grants were provided for limited sort-term assistance to schools in critical financial need.

8. Nursing student assistance:

a. Loans--The requested decrease of $13,800,000 reflects the intention to gradually phase out this program and to provide support only to students who have received prior assistance.

b. Scholarships--The decrease of $2,000,000 represents the intention to gradually phase out this program and provide support only to previous recipients.

c. Traineeships--The decrease of $13,016,000 reflects the termination of this program. Students needing financial assistance in the future will have access to the Guaranteed Loan program in the Office of Education.

9. Public Health--Federal support through these programs has been limited as compared to total expenditures by the institutions. State and local governments employ the majority of these students and thus should share greatest in their education. For this reason, no obligational authority is being sought for these programs in 1976.

10. Allied health--Federal support has been small relative to State, local, and private spending in allied health. Less than one-third of the allied health training programs were supported. The substantial growth in the allied health field in recent years has occurred largely without the impetus of Federal funding. For these reasons, no support is requested for 1976.

11. Nursing special projects--The requested decrease of $1,000,000 represents non-recurring and terminating grants.

12. Physicians opportunity--The decrease of $600,000 reflects the termination of the project.

(Health Facilities Construction)

13. Health teaching facilities construction grants--The requested decrease of $233,058,000 reflects obligations in 1975 of prior year appropriations and a proposal to make no new grant awards in 1976.

Obligations by Activity [1/]

	1975 Base Pos.	1975 Base Amount	1976 Estimate Pos.	1976 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
National health statistics	478	$21,997,000	478	$25,636,000	---	+$3,639,000
Health planning and resource development:						
(a) Transition costs:						
(1) Comprehensive health planning	---	33,750,000 [2/]	---	---	---	-33,750,000
(2) Regional medical programs	---	74,589,000 [2/]	---	---	---	-74,589,000
(3) Experimental health services delivery system	---	800,000 [3/]	---	---	---	-800,000
(b) Planning and resources development	---	18,700,000 [3/]	---	62,000,000	---	+43,300,000
(c) Capital expenditure reviews	---	7,956,000	---	4,000,000	---	-3,956,000
(d) Medical facilities construction	---	85,659,000	---	139,266,000	---	+53,607,000
Subtotal	---	221,454,000	---	205,266,000	---	-16,188,000
(Budget Authority)		(127,839,000) [4/]		(166,000,000)		(+38,161,000)
Health services research	18	42,572,000	18	26,000,000	---	-16,572,000
(Budget Authority)		(35,905,000)		(26,000,000)		(-9,905,000)
Health manpower:						
(a) Health professions:						
(1) Institutional assistance:						
Capitation grants	---	150,000,000	---	101,100,000	---	-48,900,000
Start-up and conversion	---	4,700,000	---	3,000,000	---	-1,700,000
Financial distress	---	12,954,000	---	5,000,000	---	-7,954,000
(Budget Authority)		(5,000,000)		(5,000,000)		
DC medical/dental schools	---	7,500,000	---	---	---	-7,500,000
(2) Student assistance:						
Loans	---	33,954,000	---	20,000,000	---	-13,954,000
Scholarships	---	6,900,000	---	3,500,000	---	-3,400,000
Loan repayments	---	3,000,000	---	6,000,000	---	+3,000,000
National health service scholarships	---	22,500,000	---	22,500,000	---	---
(3) Dental health activities	---	7,842,000	---	7,842,000	---	---
Subtotal	---	249,350,000	---	168,942,000	--	-80,408,000
(Budget Authority)		(241,396,000)		(168,942,000)		(-72,454,000)
(b) Nursing:						
(1) Institutional assistance:						
Capitation grants	---	34,343,000	---	---	---	-34,343,000
Financial distress	---	4,750,000	---	---	---	-4,750,000
(2) Student Assistance:						
Loans	---	22,800,000	---	9,000,000	---	-13,800,000
Scholarships	---	6,000,000	---	4,000,000	---	-2,000,000
Traineeships	---	13,016,000	---	---	---	-13,016,000
Loan repayments	---	100,000	---	2,500,000	---	+2,400,000
Subtotal	---	81,009,000	---	15,500,000	---	-65,509,000

Obligations by Activity 1/

	1975 Base		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
(c) Public health	---	20,520,000	---	---	---	-20,520,000
(d) Allied health	---	33,821,000	---	---	---	-33,821,000
(e) Special educational programs:						
(1) Health professions special projects	---	37,583,000	---	45,472,000	---	+7,889,000
(2) Family medicine residencies	---	9,500,000	---	27,000,000	---	+17,500,000
(3) Primary care residencies	---	---	---	12,000,000	---	+12,000,000
(4) Physicians' assistants	---	8,000,000	---	12,000,000	---	+4,000,000
(5) Nursing special projects	---	19,000,000	---	18,000,000	---	-1,000,000
(6) Area health education centers and other initiatives	---	12,000,000	---	16,000,000	---	+4,000,000
(7) Manpower initiatives	---	11,189,000	---	14,400,000	---	+3,211,000
(8) Special health career opportunity grants	---	6,686,000	---	9,686,000	---	+3,000,000
(9) Physician opportunity	---	600,000	---	---	---	-600,000
Subtotal, health manpower	---	489,258,000	---	339,000,000	---	-150,258,000
(Budget Authority)		(481,304,000)		(339,000,000)		(-142,304,000)
Health facilities construction:						
(a) Health teaching facilities:						
(1) Construction grants	---	233,058,000	---	---	---	-233,058,000
(Budget Authority)		(114,000,000)		(---)		(-114,000,000)
(2) Interest subsidies	---	300,000	---	3,000,000	---	+2,700,000
(Budget Authority)		(2,000,000)		(3,000,000)		(+1,000,000)
Subtotal, health facilities construction	---	233,358,000	---	3,000,000	---	-230,358,000
(Budget Authority)		(116,000,000)		(3,000,000)		(-113,000,000)
Program management	1600	48,867,000	1600	51.893.000	---	+3,026,000
(Budget Authority)		(48,281,000)		(51,851,000)		(+3,570,000)
Total obligations	2096	1,057,506,000	2096	650,795,000	---	-406,711,000
(Budget Authority)		(831,326,000)		(611,487,000)		(-219,839,000)

1/ Excludes the following amounts and positions for reimbursable activities carried out by this account: 1975 - $1,010,000 and 34 positions; 1976 - $1,010,000 and 34 positions.

2/ Of these amounts available under the continuing resolution, $29,400,000 is requested under the 1975 Planning Supplemental for CHP and $12,000,000 for RMP.

3/ These amounts reflect the 1975 Planning Supplemental request; no funds are available under the continuing resolution.

4/ Budget authority as requested in the 1975 Planning Supplemental is $60,900,000.

Obligations by Object

	1975 Estimate	1976 Estimate	Increase or Decrease
Total number of permanent positions.....	2,096	2,096	---
Full-time equivalent of all other positions.....	169	178	+9
Average number of all employees.....	2,060	2,268	+208
Personnel compensation:			
Permanent positions.....	$37,104,000	$40,543,000	+$3,439,000
Positions other than permanent.....	1,752,000	2,141,000	+389,000
Other personnel compensation.....	449,000	469,000	+20,000
Subtotal, personnel compensation....	39,305,000	43,153,000	+3,848,000
Personnel benefits.....	4,441,000	4,757,000	+316,000
Travel and transportation of persons..	3,152,000	3,457,000	+305,000
Transportation of things.....	246,000	221,000	-25,000
Rent, communications and utilities....	3,479,000	4,141,000	+662,000
Printing and reproduction.....	1,036,000	1,078,000	+42,000
Other services.....	12,759,000	12,801,000	+42,000
Project contracts.....	85,908,000	84,689,000	-1,219,000
Supplies and materials.....	595,000	669,000	+74,000
Equipment.....	612,000	805,000	+193,000
Investments and loans.....	60,029,000	29,000,000	-31,029,000
Grants, subsidies & contributions.....	845,944,000	466,024,000	-379,920,000
Total obligations.....	1,057,506,000	650,795,000	-406,711,000

Authorizing Legislation

Legislation	1976 Authorized	1976 Appropriation Requested
National Health Planning and Resources Development Act of 1974:		
Section 5 -- Miscellaneous and Transitional Provisions	Such sums as necessary	---
Public Health Service Act:		
Section 225 -- Public Health and National Health Service Corps Scholarship Training Program	2/	$22,500,000
Section 301 -- Research Grants and Contracts	Indefinite	2,142,000
Section 306 -- Traineeships for Professional Public Health Personnel	3/	---
Section 308 (i) (1) -- National Center for Health Services Research	$80,000,000	26,000,000
Section 308 (i) (2) -- Health Statistics	30,000,000	25,636,000
Section 313 -- Project Grants for Graduate Training in Public Health	3/	---
Section 729 -- Loan Guarantees & Interest Subsidies	Indefinite	2,000,000
Section 741 -- Loan Repayment and Forgiveness	Indefinite	6,000,000
Section 742 -- Health Professions Student Loans	Such sums as necessary	20,000,000
Section 767 -- Grants for Training, Traineeships, and Fellowships in Family Medicine	1/	27,000,000
Section 770 -- Capitation Grants	1/	101,100,000
Section 771 -- Start-up Assistance	1/	3,000,000
Section 772 -- Special Project Grants and Contracts	1/	45,472,000
Section 773 -- Financial Distress Grants	1/	5,000,000
Section 774 -- Health Manpower Education Initiative Awards	1/	57,786,000
Section 780 -- Scholarships Grants to Schools of Medicine, Osteopathy, Dentistry, Optometry, Podiatry, Pharmacy, or Veterinary Medicine	such sums as necessary	3,500,000
Section 789 -- Physician Shortage Area Scholarships	3/	---
Section 793 --Traineeships for Allied Health Personnel	3/	---
Section 794A -- Grants to Encourage Full Utilization of Educational Talent for Allied Health	3/	---

	1976	
	Authorized	Appropriation Requested
Section 806 -- Nursing Capitation Grants.....	3/	---
Section 808 -- Special Projects Grants & Contracts....	1/	18,000,000
Section 808 -- Nursing Financial Distress to Schools of Nursing.....	3/	---
Section 809 -- Loan Guarantees and Interest Subsidies for Construction of Schools of Nursing....	Indefinite	1,000,000
Section 810 -- Start-up Grants for New Nurse Training Programs.....	3/	---
Section 821 -- Nursing Traineeships.....	3/	---
Section 823, 830 -- Loan Repayment and Forgiveness....	Indefinite	2,500,000
Section 824 -- Nursing Student Loans.....	such sums as necessary	9,000,000
Section 860 -- Scholarships Grants to Schools of Nursing.....	such sums as necessary	4,000,000
Section 868 -- Grants to Encourage Full Utilization of Education Talent for the Nursing Professions.....	3/	---
Section 1514 -- Assistance to Entities Desiring to be Designated as Health Systems Agencies.....	Indefinite	200,000
Section 1516 -- Planning Grants.....	$90,000,000	45,000,000
Section 1525 -- Grants for State Health Planning and Development.....	30,000,000	9,500,000
Section 1526 -- Grants to State Agencies for Rate Regulation.....	5,000,000	---
Section 1533 -- Technical Assistance for Health Systems Agencies for State Health Planning and Development Agencies.....	Indefinite	7,000,000
Section 1534 -- Center for Health Planning.....	8,000,000	
Section 1613 -- Grants for Construction for modernization of medical facilities.....	130,000,000	100,000,000
Section 1635 -- Technical Assistance.....	Indefinite	300,000
Section 1640 -- Development Grants for Area Health Services Development Funds.....	75,000,000	---
The Primary care residency program has been proposed for initial authorization in 1975.....	to be established	12,000,000

	1976	
	Authorized	Appropriation Requested
Social Security Act:		
Section 1122 -- Limitations on Federal Participation for Capital Expenditures.....	Indefinite	4,000,000
Program Management - PHS Act, Section 225, Titles III, VII, VIII, XV, and XVI, and Social Security Act, section 1122.....	Inherently authorized	51,851,000

1/ Authorization expired June 30, 1974; authorized under the Continuing Resolution through June 30, 1975; extension legislation is proposed.

2/ Authorization expires June 30, 1975; extension legislation is proposed.

3/ Authorization expired June 30, 1974; authorized under the Continuing Resolution through June 30, 1975; extension legislation is not proposed.

Health Resources Administration

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation
1966	409,116,000	420,821,000	490,516,000	490,516,000
1967	559,620,000	594,511,000	619,261,000	594,761,000
1968	790,851,000	758,151,000	783,901,000	753,151,000
1969	627,391,000	521,198,000	673,268,000	619,105,000
1970	684,563,965	691,798,965	784,042,965	733,247,965
1971	655,235,000	765,885,000	903,762,000	832,612,000
1972	807,847,000	453,749,000	1,477,212,000	1,157,602,000
1973	614,251,000	1,203,215,000	1,473,265,000	1,238,144,000
1974	508,082,000	1,127,682,000	1,171,271,000	1,150,150,000
1975	147,257,000	149,133,000	147,933,000	155,433,000
Proposed Supplemental	66,500,000			
Continuing Resolution Authority		609,812,000	609,812,000	609,812,000
1976	611,487,000			
Trust Fund Transfer	42,000			

Justification

Health Resources

	1975		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	2,096	$43,746,000	2,096	$47,910,000	---	$+4,164,000
Other expenses....	---	1,013,760,000	---	602,885,000	---	-410,875,000
Total.....	2,096	1,057,506,000	2,096	650,795,000	---	-406,711,000
(Total Budget Authority)..		(831,326,000)		(611,487,000)		(-219,839,000)

The mission of the Health Resources Administration is to identify and correct current and anticipated imbalances, inefficiencies and deficiencies in the distribution, supply,equal access, utilization and costs of health care resources and services. This is done through measurement and analyses of current status and trends; definition, testing and evaluation of ways to solve health resource problems; and promotion of innovative strategies and development of those resources which will improve areas of imbalance and inefficiency. The budget for the programs of the Health Resources Administration is presented with the knowledge that authorizing legislation for the health manpower programs expired June 30, 1974. This budget, of $611,487,000 is distributed among the activities described below.

The National Center for Health Statistics will continue to gather information about the health status of the American people and the resources which are available to deliver this health care. In addition, the National Center will continue a moderate expansion in the number of developmental and implementation contracts associated with the Cooperative Health Statistics System. Emphasis will be placed on building each State's capacity to collect and process data on health manpower, facilities, utilization of services, health status of the population and vital events so that comparable statistics can be produced on an economical and timely basis for use at Federal, State and local levels. This system will also be capable of meeting the data needs of such new Federal health programs affecting local areas as Professional Standards Review Organizations and the new Health Systems Agencies. A total of $25,636,000 is requested for these activities.

Public Law 93-641, the National Health Planning and Resources Development Act of 1974 calls for the establishment of State health planning and development agencies and local Health Systems Agencies (HSAs). In addition to providing Federal grant funds for the support and operation of State and local planning and development agencies, it includes a new program for health facilities construction and modernization and authorizes funds to HSAs for developing health resources to assist in inplementing their plans. The new program would replace the Comprehensive Health Planning, Regional Medical Programs, Experimental Health Services Delivery System, and the Hill-Burton Facilities Construction authorities. A funding level of $166,000,000 is requested for these activites.

The National Center for Health Services Research is authorized under the Health Services Research, Health Statistics, and Medical Libraries Act of 1974 (P.L. 93-353) and is a statutory redesignation of the Bureau of Health Services Research. The National Center for Health Services Research has identified a number of research areas where answers are needed on how more equitably and effectively to finance and manage the nations's health care system. Specifically, these include the development of new approaches to increase productivity, equal access, and reduce costs, improving the technology for planning and regulation, greater emphasis on the labor market behavior of nonprofessional manpower, and integrating chronic illness and long-term health care more effectively and efficiently into the rest of the health delivery system. The budget request for these activities is $26,000,000.

The 1976 request of $339,000,000 for health manpower is based upon the Administration's proposed legislation in 1975 which is aimed at achieving the following objectives: encouraging the maintenance of existing enrollment levels; targeting support to solve distributional problems, both specialty and geographic; increasing productivity through more efficient use of personnel; reducing unnecessary and inequitable Federal subsidies for health professional schools and students; and increasing the representation of students in health profession schools who, due to socioeconomic factors, are financially or otherwise disadvantaged.

The budget provides for capitation grants - institutional support awarded to health professions schools on a formula basis and reflects the continued policy of gradually phasing down this particular form of institutional support awarded to health professions schools on a formula basis and reflects the continued policy of gradually phasing down this particular form of institutional and student subsidy. The basis for this phase down in this program is the high earnings potential of health professionals and general excess of qualified applicants for the number of places in health professions schools.

Two student assistance programs, the National Health Service Scholarships Program and the Health Professions Loan Repayments Program address the goal of assuring the availability of adequate health services to medically underserved populations. The traditional direct loan and general scholarship programs, which do not require public service from recipients, are proposed to be phased out. Schools will continue to make new loans from funds repaid to the schools by prior recipients of Federal loan assistance.

Several special project grant activities will focus upon increasing the quality and distribution of primary care physicians including those in the family practice of medicine; establishing, strengthening, and expanding educational

51-805 O - 75 -- 51

opportunities for physician assistants, dental auxiliaries, and nursing practitioners; and helping solve the serious problem of geographic maldistribution and under representation of health professionals. A special pre-admissions and scholarship program will support the disadvantaged enrolled in post-baccalaureate programs with stipends for pre-admission and entry-year support in the professional schools.

The Office of Health Resources Opportunity (OHRO) is included as a discrete organization and operating program component within the Office of the Administrator. OHRO provides the Agency-wide overview, stimuli, coordination and leadership to improve equity in access to health services and health careers for the disadvantaged. ORHO provides technical assistance to, and serves as, a focal point into the Agency for constituent organizations both private and public, as well as individuals, representing themselves or disadvantaged groups and/or interests so that they may secure the benefits offered by HRA programs, and in some cases anywhere within the Federal establishment. Approximately $6,000,000 of Agency contract funds will be spent on OHRO activities in addition to those activities specifically legislated or identified by the Bureaus in 1976.

The emphasis of the OHRO functions will be toward further defining and eliminating the barriers that prevent access to health services and health careers for the disadvantaged. OHRO will continue to develop, strengthen and expand its Technical Resource Center which will be the Agency focal point for information concerning the disadvantaged; study the inequities in access to health careers and health services; and expand activities on evaluation of all HRA programs and policies as they affect minority and low income groups.

HRA regional activities will show a continued increase in 1976 as a result of the additional responsibilities associated with the new planning legislation.

National Health Statistics

	1975		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	478	$8,630,000	478	$8,848,000	---	$+218,000
Other expenses	---	13,367,000	---	16,788,000	---	+3,421,000
Total	478	21,997,000	478	25,636,000	---	+3,639,000

Public Law 93-353, the Health Services Research, Health Statistics and Medical Libraries Act of 1974 establishes the National Center for Health Statistics. The Center develops and maintains reliable, general purpose health statistical data collection systems. The Center performs studies to improve health survey methods; provides technical advice and assistance on the application of statistical methods in the health and medical fields; and, exerts leadership in the continued development of a national Cooperative Health Statistics System with State and local agencies, directed toward producing comparable health data at all levels of government on a wide range of topics.

In 1976 the national survey programs will be maintained at the 1975 level. This includes the following major programs: Health Interview Survey, Health and Nutrition Examination Survey, Nursing Home Survey, Hospital Discharge Survey, Master Facility Inventory, National Ambulatory Medical Care Survey, Family Growth Survey, Family Planning Reporting System, and the Vital Statistics Program. As part of the Health Interview Survey the Center launched a pilot project designed to develop the methodology needed to accurately measure utilization of health care and the total expenditures involved in obtaining that care. The methodology will be used to develop a national survey to measure the prospective impact of National Health Insurance and of other medical care financing on the use of health services. Data gathered on the use of oral drugs and insulin by diabetics will be employed in investigating purported ill-effects associated with the utilization of oral diabetic medication.

Data collection and processing for the first national Health and Nutrition Examination Survey (HANES) were completed in 1975 and plans developed for the second HANES program which will provide a basis for measuring change in nutritional status. Examinations continued in the program to assess unmet health needs thru comparison of self-perceived health needs with findings of medical examinations. In the area of health care utilization the Center published —

preliminary reports from the first national survey of nursing homes directed at producing data on the costs and quality of care in these institutions, published data from the first survey of patients seen in physicians' offices, prepared a report on the methodology of the Family Planning Reporting System which processes annually some five million records of patient visits; and conducted a national conference which developed a minimum basic data set on long-term care.

The output from the National Survey of Family Growth is designed primarily to develop estimates of future fertility of the population for refinement of population projections, and to obtain data on maternal and infant health. Questionnaires and procedures for the second cycle of this survey, to be conducted in 1976 were pretested in 1975.

During the past year, the Center worked with thirty-nine State and local areas which were participating in one or more components of the Cooperative Health Statistics System, and with four States with research and developmental agreements. These agreements were carried over from the preceding year and no new agreements were negotiated. A principal requirement of the Cooperative System is a knowledgeable and competent staff in the State and local areas that are parties to the system. To improve these staff capabilities, NCHS increased its Applied Statistics Training Institute by presenting forty short courses in nineteen different locations throughout the United States. During 1975, these courses have an estimated enrollment of seven hundred students from all fifty states. The Center has also provided sixty technical assistance visits to State and local areas that are present or prospective participants in the Cooperative System.

Early in 1975 the Center reorganized to augment its capabilities to analyze and interpret the output from the data systems described earlier, and to improve the quantity and quality of research in survey techniques and statistical methods. In conjunction with this effort, the Center computer system was upgraded and terminals were added to provide direct access to the computer by analytic and research staff. To increase the analytic potential of Center data, forty computer tapes have been made available for use by health professionals, with all identifying information removed in order to assure the privacy of individuals to whom the data pertain. As the major health statistical organization in the United States. the Center was called upon to provide consultation and assistance in international health statistical activities. During 1975 the Center met twelve requests for consultation by the World Health Organization and other international bodies, including development of the United States position and input into the next revision of the International Classification of Diseases. The Center also responded to official requests from six foreign countries for technical assistance in health survey methods, vital statistics registration and other statistical techniques. During the year, thirty-five visits were made to the Center by researchers, dignitaries, and health statisticians from nineteen countries. Project direction was provided for twelve research projects

in five countries under the Special Foreign Currencies Program (formerly P.L. 480).

During the year the Center was active in planning management of the first meeting of the new United States National Committee on Vital and Health Statistics. This committee was created by statutory authority of Public Law 93-353 to assist and advise the Secretary of the Department on national and international health statistics problems.

The entire increase for 1976 is $3,639,000 of which $324,000 will be for mandatory items such as annualization of pay raises, one additional day of pay and increased unit costs for reimbursable contracts with other government agencies. The remaining $3,315,000 will continue the development of the Cooperative Health Statistics System by funding the Federal share of State data collection systems, supporting developmental projects undertaken by the States, and providing technical assistance to the States. These funds are estimated to increase the number of States providing the following types of data:

	Number of Additional States	Amount
Vital Statistics	12	$800,000
Health Manpower	6	360,000
Health Facilities	6	420,000
Hospital Care	3	750,000
Initial Developmental Stage	20	985,000
		3,315,000

Health Planning and Resources Development

	1975*		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	---	---	---	---	---	---
Other expenses	---	$221,454,000	---	$205,266,000	---	-$16,188,000
Total	---	221,454,000	---	205,266,000	---	-16,188,000
(Total Budget Authority)	---	(127,839,000)		(166,000,000)		(+38,161,000)
1975 Supplemental Request		(60,900,000)		(166,000,000)		(+105,100,000)

*Excludes 1973 appropriation restoration.

The Health Planning and Resources Development Program (HP&RD) is authorized under P.L. 93-641 (The National Health Planning and Resources Development Act of 1974) to implement a nationwide network of State and local health planning agencies. Guided by National health priorities, this interlocking system of agencies is to develop and implement health plans, regulate the development of new health services facilities, and support short-term projects which will lead to reasonable priced accessible and quality health care for their communities. The HP&RD program also supports a program of planning methods, development, technical assistance to State and local planning agencies, technical assistance to potential HP&RD grant applicants, and a program of health facilities construction and modernization grants. The budget requests $166,000,000 to support HP&RD in 1976.

	1975	1976	Change
Local Planning Agencies	$29,700,000	$45,000,000	+$15,300,000
(CHP(b))	(16,900,000)	(---)	(-16,900,000)
(RMP)	(12,000,000)	(---)	(-12,000,000)
(EHSRD)	(800,000)	(---)	(-800,000)
(HP&RD)	(---)	(45,000,000)	(+45,000,000)
State Health Planning and Resources Development Agencies	22,000,000	9,500,000	-12,500,000
(CHP(a))	(12,500,000)	(---)	(-12,500,000)
(HP&RD)	(9,500,000)	(9,500,000)	(---)
Medical Facilities Modernization and Construction	(---)	100,000,000	+100,000,000
Planning Methods Development	7,000,000	7,000,000	---
Technical Assistance	2,200,000	500,000	-1,700,000
Capital Expenditures Reviews	(7,956,000) 1/	4,000,000	+4,000,000
Total	60,900,000	166,000,000	+105,100,000

1/ Reimbursement from Social Security Trust Fund in 1975.

Local Planning Agencies (HSAs)

The selection and funding of the new Health Systems Agencies (HSAs) will follow the completion of the area designation process which is due to be completed by August 1, 1975. Approximately 200 HSAs will then be conditionally designated and funded for their first year costs at an average cost of $225,000 per agency or a total cost of $45,000,000. This amount will support approximately 6.5 professional and 2.5 clerical staff for each HSA with an average cost per position of $25,000 (salaries, supplies, travel, equipment, rent, and related costs). This cost does not include amounts for bonus matching payments or resource development funds. Furthermore, it is not intended nor expected that this amount would support the full-scale operations of the average finally designated local agency (the average finally designated agency may be eligible for up to $825,000 not including local matching payments or resource development funds).

The predecessor local planning agencies (i.e. CHP(b), RMPs and EHSDS) may be eligible to become the new HSA or they may join with other local agencies to become incorporated into the new HSA. The new law provided authority for funds to support the transition operations of these agencies during the change from old to new programs. Sufficient funds for this purpose are included in the 1975 appropriation.

The average HSA will be generally responsible for preparing and implementing plans designed to improve the health of the residents of their health service area; to increase the accessibility, acceptability, continuity, and quality of health services in the area; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources. In performing these responsibilities, the health systems agencies are required to:

--gather and analyze suitable data;
--establish health systems plans (goals) and annual implementation plans (objectives and priorities);
--provide either technical and/or limited financial assistance to people seeking to implement provisions of the plans;
--coordinate activities with PSRO's and other appropriate planning and regulatory entities;
--review and approve or disapprove most applications for Federal funds for health programs within the area;
--assist States in the performance of capital expenditure reviews;
--assist States in making findings as to the need for new institutional health services proposed to be offered in the area;
--assist States in reviewing existing institutional health services offered with respect to the appropriateness of such services;
--annually recommend to States projects for the modernization, construction, and conversion of medical facilities in the area.

State Health Planning and Resources Development Agencies

Half of the State agencies are projected to be funded in 1975. The remaining one-half of the new State Health Planning and Resources Development Agencies (twenty-eight) will be designated and funded by the second quarter of 1976.

The 1976 request for this purpose is $9,500,000. The average State agency will have a staff of eighteen with an average cost of $450,000 for the first year. The maximum Federal share of this cost is seventy-five percent or $337,500 per agency. The projected staffing requirement of thirteen professionals and five clericals reflects a slight increase over the actual professional staff on board in State agencies currently funded through CHP, Hill-Burton, and Section 1122 authorities, and is based on the increased functions which the new State agencies will perform. The average cost per person is again estimated at $25,000 for salaries, supplies, travel, equipment, and indirect costs. In addition to:

(1) continuing the planning functions performed by the State CHP agency;
(2) continuing Section 1122 functions authorized under the Social Security Act (i.e., review of capital expenditures proposed by facilities desiring full reimbursement under Medicare and Medicaid); and
(3) administering the funds allotted to the State under Title XVI authority for medical facilities construction grants (a function performed previously by the Hill-Burton State agency under Title VI);

the State agencies will also:

(4) provide staff support to the Statewide Health Coordinating Council;
(5) coordinate the implementation of the State health plan which includes the medical facilities plan;
(6) administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed with the State; and
(7) review all existing institutional health services being offered in the State at least every five years.

During the transition from the old to the new program, the predecessor CHP and Hill-Burton State planning agencies are supported from the 1975 appropriation or with unobligated balances from prior appropriations. In addition, $4,000,000 is requested to support the review of capital expenditure reviews by the transition agencies. After new State and local agencies are designated funds are included in the State and local planning grants under the new law for this review activity. Capital expenditure review has been one of the most successful activities in which the present State and local agencies have participated. It has been estimated that Federal support for $200,000,000 of unnecessary capital expenditures was avoided through this review process in the first year of its operation.

Among the major tasks of the newly funded State agencies is the provision of staff support to the Statewide Health Coordinating Council (SHCC). The SHCC members are resident consumers and providers. Major SHCC responsibilities entail the preparation and review of the State health plan (which incorporates all the local HSA plans); the review and approval of the State medical facilities plan; and the review and approval of State applications for Federal support for various health programs (such as community mental health programs).

Medical Facilities Modernization and Construction

The 1976 request for medical facilities construction grants is $100,000,000.

	1976
State allotment.....	78,000,000
Project grants.....	22,000,000
Total.....	100,000,000

The allotments to the States are determined on the basis of population, financial need, and the need for medical facilities projects. As a condition to the receipt of funds, a State Agency must have a State medical facilities plan which has been reviewed and approved by both the Department and the Statewide Health Coordinating Council for its consistency with the State health plan. This facilities plan must include a list of the projects for which assistance will be sought and of the priorities for the funding of these projects.

Grants made from allotments to the States may generally only be used for the modernization of outdated existing facilities; for construction of outpatient facilities which will serve as alternatives to inpatient hospitalization; or for conversion of existing facilities in order to produce new services. Although funds may also be used for new inpatient facility construction, the amount which can be obligated is limited to a maximum of 20 percent of the amount of a State's allotment available for obligation in that fiscal year, and may only be used in areas of the State which have experienced recent rapid population growth.

Project grants are made directly by the Department to publicly owned health facilities for special medical facilities construction projects designed to eliminate or prevent imminent safety hazards or to avoid noncompliance with State or voluntary licensure or accreditation standards. Applications for both project and State allotment grants must set forth a number of assurances, including assurances to provide a reasonable volume of free care for those who cannot afford to pay and a willingness to provide service to all residents of the community.

Planning Methods Development

The request for the new Planning Methods Development program is $7,000,000. The Planning Methods Development program has the two-fold responsibility for developing efficient planning methods and techniques to begin to answer these questions and also for providing technical assistance to State and local agencies in evaluating, adopting, and utilizing new planning methods.

In order to support this critical aspect of the program, the development of planning methods and techniques will be accomplished through a wide ranging combination of Federal staff, grant, and contract activities.

The activities to be initiated in 1976 include the development of: guidelines and procedures for cost-benefit analyses by health planners; methods to estimate the impact of health planning decisions on the health services delivery system; improved techniques for small area population projection; strengthened procedures and standards for the review of existing institutional health services; methods that health planners can use to consider the impact of developing medical technology in their health plans; and more accurate techniques for determining facilities, manpower and service needs of an HSA area.

It is intended that the Federal effort be free of duplication by using existing expertise and capacity within the Health Resources Administration as well as in other health organizations and agencies whenever possible and appropriate. Toward that end, the National Center for Health Statistics will directly participate in the assessment of data requirements, interfacing with the Cooperative Health Statistics System in order to meet many of the data needs of the new planning effort. Among the materials to be provided by DHEW to the Health Systems Agencies are the specifications of minimum data needed to determine:

(1) the health status of the residents of an area;
(2) the status of the health resources and services of such an area; and
(3) the utilization of health resources and services in the areas.

The National Center for Health Services Research will also work closely with the planning program in many of these areas. Current research findings that have an influence on planning methods and practices will be identified and provided to the agencies. In addition, planning questions that require research will be pursued jointly by health planning and health service research staffs.

Technical Assistance

This request includes $500,000 to support two types of technical assistance: (1) the provision of technical assistance to potential HSAs, and (2) the provision of technical assistance to potential applicants for facilities construction funds.

Both headquarters and regional office staff efforts will involve developing written materials, manuals and guidelines; conducting training and education sessions, as well as making on-site visits.

The Office of Health Resources Opportunity will supplement these activities by providing special inputs to represent and reinforce consumer and minority interest and participation.

Health Services Research

	1975 Pos.	1975 Amount	1976 Pos.	1976 Amount	Increase or Decrease Pos.	Increase or Decrease Amount
Personnel compensation and benefits.....	18	$305,000	18	$800,000	--	+$495,000
Other expenses.....	--	42,267,000	--	25,200,000	--	-17,067,000
Total.....	18	42,572,000	18	26,000,000	--	-16,572,000
(Total Budget Authority)...		(35,905,000)		(26,000,000)		(-9,905,000)

*Excludes 1973 appropriations restorations

The National Center for Health Services Research (NCHSR) is authorized under Public Law 93-353, the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. It has authority under Section 304(b) of the Public Health Service Act, as amended, to support training for health services researchers and under Sections 305 and 308 to support health services research, demonstration and evaluation projects through grants and contracts.

The need to improve the knowledge of the health care delivery system is evidenced by the recent history of rising prices and increasing demand for services, of dissatisfaction with the accessability, availability and quality of care, of new public policy initiatives, and of an overall economic setting which is beset with both inflation and unemployment. The need to moderate costs and increase access to productive and effective health services becomes clearer every day. It is to these ends to which the National Center is committed.

There is much evidence that however difficult the problems of health care policy appear today, the past decade of research has provided us with a greater capacity to deal with them. To continue this effort responsibly requires not only undertaking and supporting research, but also organizing and structuring the National Center in such a way as to ensure that knowledge flows directly into the decision-making process. The National Center serves in a liaison role, serving as an interface between the users of research results and the research community itself. In planning its research agenda, NCHSR continually seeks the counsel of its constituents: users and providers of health services; health planners; the research community; and policy makers in the Legislative and Executive branches.

Public Law 93-353 requires the Secretary to spend 25% of the appropriation for health services research for direct research activities rather than through grants or contracts; however, the Department has submitted a proposal to the Congress to repeal the 25 percentum earmarking. The National Center estimates that it will spend $1,000,000 in 1975 on intramural research activities and $3,900,000 in 1976. Initial personnel for the new intramural research program have been redirected from the current program management staff and will include persons hired under the Service Fellows Program and Intergovernmental Personnel Act. This narrative does not distinguish between intramural and extramural research but, rather, identifies areas of research emphasis regardless of the manner in which they are undertaken.

Distribution of Budget Authority

	1975 Estimate	1976 Estimate	Increase or Decrease
(1) Research grants and contracts	$32,905,000	$21,200,000	-$11,705,000
(2) Intramural research	1,000,000	3,900,000	+2,900,000
(3) Research training grants and fellowships	2,000,000	900,000	-1,100,000
Total	35,905,000	26,000,000	-9,905,000

	1975 Estimate	1976 Estimate	Increase or Decrease
(1) Research Grants and Contracts:			
Research, Evaluation and Demonstration Grants:			
Non-competing continuations	15,000,000	7,100,000	-7,900,000
New and renewal grants	12,405,000	5,600,000	-6,805,000
Supplementals	500,000	500,000	---
Subtotal	27,905,000	13,200,000	-14,705,000
Contracts:			
Continuations	1,500,000	3,000,000	+1,500,000
New contracts	3,500,000	5,000,000	+1,500,000
Subtotal	5,000,000	8,000,000	+3,000,000
Total	32,905,000	21,200,000	-11,705,000
(2) Intramural research:			
Personnel compensation and benefits	305,000	800,000	+495,000
Other expenses	100,000	700,000	+600,000
Contracts	595,000	2,400,000	+1,805,000
Total	1,000,000	3,900,000	+2,900,000

Distribution of Research Grants and Contracts by Priority Areas

	1975 Estimate	1976 Estimate	Increase or Decrease
Research Issues:			
1. Insurance Plans	$3,000,000	$2,000,000	-$1,000,000
2. Manpower	3,000,000	2,200,000	-800,000
3. Planning and regulation	3,000,000	1,600,000	-1,400,000
4. Cost containment, productivity, impact of inflation	4,000,000	2,000,000	-2,000,000
5. Disadvantaged	1,500,000	1,800,000	+300,000
6. Quality of medical care	9,000,000	5,700,000	-3,300,000
7. Chronic illness and Long-Term Care	4,000,000	1,300,000	-2,700,000
8. Technology	5,000,000	3,000,000	-2,000,000
9. Research centers	1,000,000	4,000,000	+3,000,000
Total	33,500,000	23,600,000	-9,900,000

1. Insurance plans

In 1976, approximately $2,000,000 will be spent on insurance plan-related research. In addition to an increased interest in catastrophic illness, the National Center will continue to analyze the general impact of financing on both the demand for and supply of health services.

Throughout the ongoing debate over National Health Insurance, research funded by the National Center has served as a major data source for estimating the total cost of specific proposals and for projecting utilization rates at various income levels, given alternative co-insurance rates and deductibles.

Considerable attention has been devoted to the question of financing treatment of catastrophic illnesses. In October 1974, the National Center invited a group of researchers, providers and Congressional staff members to discuss the issue of financing catastrophic care and to identify useful areas for research. Current studies, which indicate significant variations in cost, incidence and utilization by type of disease, will hopefully result in a better understanding of the issue and, ultimately, a more effective policy response.

2. Manpower

In 1976, an estimated $2,200,000 will be used to support health manpower studies. There will be increased emphasis on the labor market behavior of non-professional health manpower and impact of collective bargaining on costs and supply of personnel.

NCHSR plans a major change in emphasis in 1976. The experience of the Economic Stabilization Program, the growth of collective bargaining in the industry and the recent extension of the National Labor Relations Act to cover employees of non-profit health facilities suggest that the labor market behavior for non-professional health manpower is inadequately understood. Capturing the training potential of health industry employment is one challenge which could lead to reduced turnover, more meaningful careers for health industry employees and more efficient delivery of services.

3. Planning and regulation

In 1976, $1,600,000 will be devoted to planning and regulation analyses with emphasis on developing more effective means of storing, retrieving and using data in planning agencies.

The major planning and regulation effort of the National Center for Health Services Research has been its Experimental Health Services Delivery Systems Program (EHSDS). Many of the lessons from this experience were incorporated into the new planning legislation, Public Law 93-641.

The National Center will continue to work closely with the health planning and resources development program to make available the results of its past research in this area and to identify new areas for analysis. The ongoing NCHSR investment in computer systems and data analysis capacity for health planning and optimal resource allocation will be invaluable to this new effort, as will more narrowly defined projects such as the development of a more effective system for storing and distributing whole blood supplies. In addition, NCHSR will continue to monitor and analyze the national experience with rate setting and certification of need in an effort to evaluate regulation as a tool in the planning process.

4. Cost containment, productivity, and impact of inflation

In 1976, the National Center will spend $2,000,000 on research directed at cost containment, productivity, and the impact of inflation.

The cost of health services has risen more rapidly in the last five years than virtually any other segment of our economy. NCHSR undertook a major initiative in 1975 to identify the causes and implications of that trend.

Research supported by NCHSR has clearly demonstrated that only part of the increases in the cost of health services is attributable to increases in the cost of producing those services. Changes in the nature of the services are also a major factor. The National Center will continue to examine the "intensity of care" issue and attempt to identify ways of motivating providers to respond to cost containment opportunities by reducing prices, rather than by increasing the quantity of care delivered.

Inflation both redistributes services and places added burdens on the delivery system in ways that are inadequately understood. As input to the 1974 Summit Conference on Inflation, a series of brief studies were commissioned by NCHSR to assess the impact of inflation on aspects of health services delivery such as financing programs, training, access, capital development and long-term trends in organization.

One important impact is the inability of providers to respond to technological innovation because of tight credit and an inadequate cash flow. As a result, NCHSR will devote more attention in 1976 to influencing the productivity of manpower by altering work setting arrangements rather than focusing almost entirely on developing capital substitution for labor, as has been true in the past.

5. Disadvantaged

In 1976, an estimated $1,800,000 will be devoted to research on patterns of access to care for the disadvantaged and the impact of rising inflation and unemployment.

Lack of knowledge of how and when to use the health care system, coupled with inefficient organization of health services delivery for persons who cannot afford the luxury of private care, argue for a targeted research program directed toward the disadvantaged persons. Rising unemployment and increasing rates of inflation further emphasize the need for such research. In addition, further factors acting as barriers to access for the disadvantaged will be studied. Two such barriers are transportation and language.

Research undertaken in 1975 suggests that inflation in the health sector affects the poor more strongly than other parts of the population. In addition, the loss of health insurance coverage associated with unemployment is most disastrous for those who do not have the financial resources to compensate. In 1976, efforts will be devoted to defining the impact of rising costs, inflation and unemployment on the disadvantaged.

6. Quality of care

In 1976, it is estimated that $5,700,000 will be used to support studies related to assessing, assuring or improving the quality of care.

Past research of the National Center has significantly influenced national efforts to evaluate and influence the quality of medical care which is actually delivered. NCHSR's Experimental Medical Care Review Organization Program (EMCRO) has demonstrated a quality assurance strategy which was formalized in the recent PSRO legislation even before the EMCRO evaluation was completed. Research has also suggested that many measures of quality which we currently use are inadequate either because they fail to adequately measure the outcome of a particular treatment or because they involve too much of a time-lag after treatment to be useful. Major thrusts of the National Center's effort in 1976 will be evaluation of quality assessment strategies currently under development and the identification of possible new measures. An important activity involves the development of indices for specific disease conditions which can be applied shortly after treatment is initiated.

Another major area of emphasis in quality research is the development of vehicles for improving the quality of care. Computerized medical information systems appear most promising in this area. Systems which are currently being examined include one to prevent accidental prescriptions of adversly interacting drugs and another to maintain patient histories in terms of the specific medical problems encountered.

7. Chronic illness and Long-Term Care

In 1976, the National Center will spend an estimated $1,300,000 on analyses directed specifically at the chronically ill and long-term care.

The optimal organization, structure and performance of a health care delivery system for individuals with either indefinite or repetitive episodes of care may be significantly different from an acute care system. The National Center plans to continue identifying and assessing innovative and possible cost-effective means of delivering long-term care.

The potential reductions in expenditures for health services both to the Federal government and the Nation as a whole are self-evident. However, current research comparing Medically Oriented Housing to more traditional health facilities suggests that significant medical and social benefits can result as well. Efforts will continue to identify ways of improving both the quality of

care and the effectiveness of services in nursing home settings.

Current legislative activity and administration concerns have been focused on alternatives to institutional care. The National Center is presently supporting projects in relation to implementation of Section 222 of Public Law 92-603 in developing demonstrations to determine cost-effectiveness of day care, homemaker service and intermediate care.

8. Technology

In 1976, the National Center anticipates spending about $3,000,000 on technology-related research with a major emphasis on evaluation rather than development.

Past efforts of the National Center in the area of health services technology have significantly affected the organization and delivery of care in this country.

Automated EKG's, increasing at a rate of about 4,000,000 EKG's annually, were developed and demonstrated by NCHSR. The work of the National Center with medical information systems, particularly integrated hospital information systems, have significantly improved the potential performance of hospitals and ambulatory care settings.

In addition, NCHSR has supported both the development of and the specification of standards for the MUMPS medical computer language, which has proved a cost-effective technology for small institutions with a wide variety of applications. The value of this activity is indicated by the use of MUMPS in the NIH Clinical Center, the National Library of Medicine and the Department of Defense. Although a significant part of the NCHSR effort in technology has been on development, there is a growing need to expand our efforts in evaluating the impact of various technologies and identifying opportunities for technological innovations. The 1976 program plan reflects this shift.

9. Health services research centers

Section 305(d) of the Public Health Service Act, as amended by Public Law 93-353, calls for the establishment of at least six multi-disciplinary health service research centers.

We anticipate these Centers being funded early in 1976 at an estimated cost of $4,000,000. This figure includes support for two existing Centers under an old program which is being phased out, as well as the six new Centers to be funded under the new program.

These projects are to be centers of excellence, free to design and undertake health research activities of particular National, regional and/or local importance.

Two sites selected for Centers will also be designed as National Special Emphasis Centers:

1. The Health Care Technology Center will focus on evaluating both the potential impacts of existing or proposed technologies and the actual effects of past technological changes on various aspects of provider and system performance such as cost, access, and effectiveness of treatment.

2. The Health Care Management Center will focus on improving the management, organization, and productivity of the health sector. In addition, the Center will be expected to disseminate its research findings by providing technical assistance and consultation services, as well as to conduct training and continue education programs.

(3) Research and Development Training

	1975 Estimate	1976 Estimate	Increase or Decrease
Training grants:			
Non-competing continuations	$1,792,000	$870,000	-$922,000
Supplementals	28,000	---	-28,000
Subtotal	1,820,000	870,000	-950,000
Fellowships:			
Non-competing continuations	175,000	30,000	-145,000
Supplementals	5,000	---	-5,000
Subtotal	180,000	30,000	-150,000
Total	2,000,000	900,000	-1,100,000

The National Center has in past years awarded research training grants and fellowships to support the training of investigators qualified to design and conduct the complex types of analysis, research, and development required to improve health services. Research training activities were begun to be phased out in 1973. In 1976, the National Center will support only grants and fellowships for which support was committed in an earlier year. No awards to new training programs or fellows will be made under this program. The 1976 level of funding is $900,000 and reflects a decrease of $1,100,000 below the 1975 level.

During 1975, 76 grants were awarded to institutions and community education organizations to develop and deliver improved curricula for all levels of education and training associated with Emergency Medical Services. Training programs include professional and allied health personnel, nurses, advanced and basic emergency medical technicians and physicians. Particular attention is being given to the support of training programs that will contribute to the establishment or operation of emergency medical services systems.

51-805 O - 75 -- 52

Health Manpower

	1975* Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	---	---	---	---	---	---
Other expenses	---	$489,258,000	---	$339,000,000	-	-$150,258,000
Total	---	$489,258,000	---	339,000,000	--	-150,258,000
(Total Budget Authority)		(481,304,000)		(339,000,000)		(-142,304,000)
*Excludes 1973 appropriation restorations						
Health professions		249,350,000		168,942,000		-80,408,000
Nursing		81,009,000		15,500,000		-65,509,000
Public health		20,520,000		---		-20,520,000
Allied health		33,821,000		---		-33,821,000
Special educational programs		104,558,000		154,558,000		+50,000,000
Total		489,258,000		339,000,000		-150,258,000

The 1976 budget for Health Manpower activities is presented with the knowledge that legislative authorization for these programs which expired June 30, 1974, is now in the process of being renewed by Congress. The Department is working with the Congress to develop new legislation. The funds requested in 1976 are based upon the Administration's proposed legislation in 1975. It is aimed at achieving the following objectives: encouraging the maintenance of existing enrollment levels; targeting support to solve distributional problems, both specialty and geographic; increasing productivity through more efficient use of personnel; and reducing unnecessary and inequitable Federal subsidies for health professional schools and students.

Health Professions

	1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
Health professions:			
Institutional assistance..	$175,154,000	$109,100,000	-$66,054,000
Student assistance.....	66,354,000	52,000,000	-14,354,000
Dental health activities..	7,842,000	7,842,000	---
Total health professions	249,350,000	168,942,000	-80,408,000

Support is provided for education in the health professions to provide basic financial assistance to health education institutions and students and to reduce the need for dental services through the application of disease prevention and control measures.

Institutional Assistance:

	1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
Institutional assistance:			
Capitation.....	$150,000,000	$101,100,000	-$48,900,000
Start-up and conversion.	4,700,000	3,000,000	-1,700,000
Financial distress.....	12,954,000	5,000,000	-7,954,000
D.C. medical/dental schools.....	7,500,000	---	-7,500,000
Total Institutional assistance.....	175,154,000	109,100,000	-66,054,000

Capitation -- The 1976 request of $101,100,000 for these grants reflects a $48,900,000 decrease from 1975. These grants are awarded on a complex formula basis to schools of medicine, dentistry, osteopathy, veterinary medicine, optometry and podiatry. The budget request of $101,100,000 reflects the administration's policy to gradually phase down this enrollment increase incentive program while at the same time promoting continuance of those enrollment gains already achieved. These funds will support an estimated 300 schools.

Start-up and conversion -- Start-up grants may be awarded for up to four years to new schools of medicine, dentistry, and osteopathy to permit such schools to start earlier or to substantially increase their enrollments above what would otherwise be possible. An amount of $3,000,000 is requested to support nine schools in 1976.

Financial distress grants -- Schools that demonstrate they are in serious financial need are eligible to apply for support under this program. Those schools aided by financial distress grants are required to conduct appropriate activities to alleviate their dependence on these grants, including improvement of their own fiscal and management operations. The $5,000,000 requested in 1976 will provide support to twelve health professions schools.

D.C. Medical/Dental Schools -- Awards under this activity are to private medical and dental schools in the District of Columbia which have demonstrated critical financial need but which also plan management improvement activities to overcome continued reliance on this form of support. In 1975, $7,500,000 was awarded to George Washington University School of Medicine and Georgetown University Schools of Medicine and Dentistry.

No funds are requested for this program in 1976. These schools will be able to compete with other health professions schools for funds under other health manpower programs in 1976.

Student Assistance:

	1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
Student assistance:			
Loans.....	$33,954,000	$20,000,000	13,954,000
Scholarships.....	6,900,000	3,500,000	-3,400,000
National health service scholarships.....	22,500,000	22,500,000	---
Loan repayments.....	3,000,000	6,000,000	+3,000,000
Total Student assistance.	66,354,000	52,000,000	-14,354,000

Training in the health care field is an excellent personal investment which promises very substantial returns. Thus, the decision has been made that health professions students should begin to absorb a greater portion of their educational costs. Students needing financial assistance will be able to take advantage of an improved and expanded guaranteed student loan program which is administered by the Office of Education for graduate level training.

Student loans -- The 1976 request for loans to students of health professions is $20,000,000. An estimated 16,000 loans to previous recipients will be supported with these funds. These loans, awarded by the schools, are intended to assist students with limited financial resources pursuing careers in the health professions. Though this particular direct loan program is being gradually phased out, the student loan guarantee program in the Office of Education is being expanded. It is proposed that both the annual and the total loan ceilings be increased, making this form of financial assistance more accessible.

Scholarships -- Health Professions scholarships are awarded to students of exceptional financial need taking into account their educational and living costs for the year compared with the financial resources available to them. In 1976, the Health Professions Scholarship program will make awards through the participating schools to those students who have previously been assisted under this program. This program is being gradually phased out in favor of conditional scholarship programs requiring the recipient to serve in the public interest for a specific period of time. For this reason, the amount requested for 1976 ($3,500,000) reflects a decrease of $3,400,000 from the 1975 estimate. It is expected that nearly 4,000 students previously supported will be assisted with these funds.

National health service scholarship program -- This program authorized scholships for students in the Health Professions in exchange for a specified period of service in various public health service programs, including the National Health Service Corps, the Indian Health Service, Public Health Service Commissioned Corps, Bureau of Prisons and U.S. Coast Guard. In 1976, the $22,500,000 requested for this program will provide approximately 2,300 scholarships.

Loan repayments -- The Health Professions Loan Repayments Program began in 1974, and a total of $6,000,000 is requested to continue this program in 1976. These funds are used for several purposes. When a health professional signs a written agreement to serve two years in the National Health Service Corps or to practice in shortage areas these funds are used to repay sixty percent of that individual's education loan. In addition, if a health professions student receiving a loan from the capital fund serves an additional year in a shortage area then eighty-five percent of his educational loan(s) will be repaid. Also if a health professions student fails to complete his studies, the funds may be used to repay outstanding loan(s) made for such studies if the student (a) is in exceptionally needy circumstances (b) is from a low-income or disadvantaged family, and (c) cannot be expected to resume his studies within two years. Approximately 650 loans will be repaid in 1975 and 1,300 in 1976.

Dental Health Activities:

	1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
Dental health.....	$7,842,000	$7,842,000	---

The Dental Health Program is the Federal focus with regard to dental education, practice, and manpower research. As such, it provides the professional expertise and leadership necessary to plan, coordinate, evaluate, and support development and utilization of the Nation's dental health manpower resources to improve the quality and quantity of dental care in our country. This includes programs for the development, use, credentialing, and distrubution of dental personnel, including dentists, dental hygientists, expanded function auxiliaries, dental assistants, and dental technicians. It also performs research and development projects and demonstration programs on the interrelationships between individual members of the health care team, their tasks, educational regimens and related training modalities. Consultation and technical assistance is also provided to Federal and nonfederal agencies. It is estimated that 29 new and 35 continuation projects will be supported with these funds.

Nursing

	1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
Nursing:			
Institutional assistance:			
Capitation grants.....	$34,343,000	---	-$ 34,343,000
Financial distress.....	4,750,000	---	-4,750,000
Student assistance:			
Loans.....	22,800,000	$9,000,000	-13,800,000
Scholarships.....	6,000,000	4,000,000	-2,000,000
Traineeships.....	13,016,000	---	-13,016,000
Loan repayments.....	100,000	2,500,000	+2,400,000
Total	81,009,000	15,500,000	-65,509,000

Institutional Assistance:

Capitation Grants -- The Nurse Training Act of 1971 authorized formula capitation grants to support educational programs in nursing schools of all types with extra amounts to encourage expansion of enrollment and the training of nurse practitioners. The program funded almost 981 awards for nursing programs in 1975.

Traditionally, the largest percentage of nursing schools, i.e., hospital-based institutions, have been financed through patient care costs. No convincing case has been made that limited Federal resources should be used to replace the traditional resources of financial support for such training. In addition, the ability of nursing schools to expand enrollments prior to the availability of capitation support suggests that this form of institutional support is not essential, therefore no funds are requested in 1976.

Financial Distress -- Financial Distress grants assisted some schools of Nursing which were in serious financial straits and required additional Federal Assistance for a limited period of time. In 1975, 60 schools were supported.

In 1976 no funds are being requested since the financial distress program was intended to be a short-term program providing temporary assistance to nursing schools.

Student Assistance:

Student loans -- There has been a substantial increase in the numbers of nurses and the nursing student loan program has contributed to this growth. The availability of Federal student loans as a supplement to other types of student financial assistance has made nursing education possible for many students who could not otherwise go to school. Based upon as estimated average loan of $800, approximately 11,250 students will receive loans in 1976. The funds requested are intended to provide support to students who have received prior assistance. This program decrease of $13,800,000 reflects the reduced need for a specific nursing student loan program.

Scholarships -- In an effort to provide improved nursing care to underserved areas and to bring about a reduction in the then existing nursing shortage, special Federal scholarship programs were initiated in 1968 to encourage young people in exceptional financial need to attend nursing school. Phase-out of this program was begun in 1975. In 1976, this scholarship program will continue to be phased-out and the $4,000,000 requested is intended to support approximately 4,000 students who were prior recipients of such scholarships. This phase-out is, in part, due to the fact that the number of nurses has steadily increased over the years and the necessity for a special nurse scholarship program is no longer required. Also, undergraduate nursing students now have access to the expanded Basic Opportunity Grants program in the Office of Education.

Traineeships -- This program provided financial assistance to registered nurses undertaking advanced education preparation for leadership positions. Traineeships provided stipened, tuition, and dependence allowances which enable nurses to prepare for positions as teachers, administrators, or supervisors for nursing services in institutional and community settings. In 1975, $13,016,000 was available for this program which supported 3,000 students and 136 participating schools. No funds are being requested in 1976. Students needing financial assistance in the future will have access to the Guaranteed Loan Program in the Office of Education.

Loan repayments -- This program provides for the repayment of nursing educational loans of nurses who agree to serve in a shortage area or who fail to complete their educational program and are financially disadvantaged. It is estimated that 1,000 loans will be repaid in 1976.

Public Health

	1975 Estimate	1976 Estimate	Increase or Decrease
Institutional Assistance....	$11,400,000	--	-$11,400,000
Student Assistance.....	9,120,000	--	-9,120,000
Total.....	20,520,000	--	-20,520,000

Support for Public Health training was first authorized in 1956. Federal support for these programs has been in the form of formula grants, traineeships, and public health project grants. Formula grants supported the educational programs in the schools of public health and the project grants and traineeships were received by other schools and institutions as well. The basic legislative authorization for these programs expired at the end of 1974.

The $20,520,000 available for Public Health programs in 1975 supported 57 graduate projects, 18 formula grants to schools of public health and 344 traineeships.

No funds are requested for these programs in 1976. Students pursuing a professional education in public health in need of financial aid will have access to general financial assistance such as loan guarantees.

Allied Health

	1975 Estimate	1976 Estimate	Increase or Decrease
Institutional Assistance.....	$30,158,000	--	-$30,158,000
Student Assistance.....	3,563,000	--	-3,563,000
Educational Assistance...	100,000	--	-100,000
Total.....	$33,821,000	--	-$33,821,000

The Bureau of Health Resources Development's allied health programs have been directed toward improving the quality of allied health training and increasing training opportunities. Since 1967, Federal funds have been provided on a selective basis to upgrade and expand the curricula and support teacher training and development in the allied health professions. The basic legislative authorization for these programs expired at the end of 1974.

Projects supported in 1975 were: Operation MEDIHC, projects of national significance such as development of models to improve coordination, efficiency, effectiveness, and quality of educational

programs; development of new methods for credentialing in the allied health professions, including proficiency testing; and the potential impact of new credentialing methods on improving manpower distribution and utilization. Traineeships were awarded for both long-term degree-oriented academic training and special short-term training designed to expand the capabilities of allied health professionals who are already serving in teaching or other positions of leadership.

No funds are requested for these programs in 1976.

Special Educational Programs

	1975 Estimate	1976 Estimate	Increase or Decrease
Special educational programs:			
Health professions special projects.....	$37,583,000	$45,472,000	$+7,889,000
Family medicine residencies	9,500,000	27,000,000	+17,500,000
Primary care residencies...	---	12,000,000	+12,000,000
Physician assistants.....	8,000,000	12,000,000	+4,000,000
Nursing special projects...	19,000,000	18,000,000	-1,000,000
Area health educational centers and other initiatives.....	12,000,000	16,000,000	+4,000,000
Manpower initiatives.....	11,189,000	14,400,000	+3,211,000
Special health career opportunity grants.....	6,686,000	9,686,000	+3,000,000
Physician Opportunity.....	600,000	---	-600,000
Total Special educational programs.....	104,558,000	154,558,000	+50,000,000

Health professions special projects -- In 1976, the $45,472,000 requested for Special project grants and contracts will be used to meet previous commitments. These funds have been, and will continue to influence schools to undertake programs of interdisciplinary training, primary care, and increasing enrollment of minority and women students. New projects will be initiated addressing problems of speciality and geographic maldistribution.

Family medicine residencies -- These funds are used for the initial operation, expansion or improvement of family practice residency programs at eligible hospitals. The $9,500,000 in 1975 supported the continuation of 73 projects. Approximately 1,500 residents received training in 1975. The 1976 request of $27,000,000 will continue the support of 73 projects and will fund 92 new projects in 1976. A minimum of 3,000 residents are expected to be trained in 1976.

Primary care residencies -- There is a need to promote and assist in developing model primary care residency programs in order to foster rapid integration of the most promising methods into this critical area of the Nation's health education systems. The 1976 request of $12,000,000 will support 48 programs offering 290 residency years of instruction.

Physicians assistants -- Contracts have been awarded to schools of medicine, dentistry, and other educational entities to plan, operate, and expand programs for the training of physician's assistants and expanded duty dental auxiliaries. Emphasis is placed on the preparation of these mid-level practitioners to serve in primary care settings and in medically underserved areas, as differentiated from assistants being trained to work with medical specialities. The expanded duty dental auxiliary (dental therapist) program awards contracts to develop programs which will train dental auxiliaries to perform specific dental functions previously provided only by the dentist.

In 1975, $8,000,000 was awarded to assist in the continued and expanded development of 40 physician's assistant training programs and 13 programs for the expanded function dental auxiliaries. All of the physician's assistant programs represent a continued effort in the training of assistance to the primary care physician, there were a total of 2,000 enrollees. The physician's assistant graduates have been employed not only in solo and group practices but also in the delivery of primary care in such settings as mental health facilities and state operated VD clinics. As a result, many large populations being treated for a specific disease entity were monitored for their general physical well being.

In 1975, 13 programs for the expanded function dental auxiliary training programs will be supported. Many of those new instructors, after training, will be conducting continuing education courses required by the auxiliary following graduation. There were 500 auxiliaries and about 200 instructors enrolled in the 13 programs.

The 1976 request of $12,000,000 will support an increase of 23 programs for the assistance of the primary care practitioners for a total of 63 programs with an enrollment of 3,100 students. The number of contracts for the expanded duty dental auxiliary program will increase to 23 projects with an expected enrollment of 620 students.

Nursing special projects -- The national commitment to equalize access of health care and services underscores the need to concentrate resources on the preparation of nurses prepared to provide care in ambulatory and community settings, and to provide advanced training for specialized nurse practitioners. To accomplish this objective, a number of courses of action must be undertaken simultaneously: (1) curriculum revision must be effected at both initial and advanced levels as a foundation for integrating certain medical assessment and management skills in the traditional nursing role; (2) programs of continuing education must be revitalized to prepare practicing nurses for new responsibilities on the therapeutic team and to facilitate reentry into the profession for those whose skills are obsolescent; (3) programs to train additional numbers of nurses for primary care and for highly specialized care must be initiated and expanded; and (4) increase the enrollment and full utilization in nursing of individuals who due to social economic factors, are financially or otherwise disadvantaged. The budget provides $18,000,000 for these efforts and for other types of projects aimed at improving nursing practices. Of this amount, approximately two-thirds will support ongoing projects.

Area health education centers -- A system or arrangement that links health service organizations and educational institutions in a way that serves both the student and the surrounding community. Of equal importance in the AHEC concept are areawide and statewide efforts to coordinate health manpower training in relation to manpower needs in a coordinate system of health services. This coordination improves the accessibility and quality of health care in the service area. These contracts are being used to demonstrate viable methods for conducting decentralized programs of medical education, with emphasis on the clinical training of medicine and other health professions students in the primary care disciplines. Through these efforts, approximately 15,000 students in undergraduate, graduate and short-term training programs in various health fields take a portion of their clinical training in hospital and ambulatory care settings in scarcity areas. In 1976, 11 medical schools and university health science centers will be awarded contracts to initiate the development and operation of 27 area health education center sites in medically underserved areas.

Manpower initiatives -- In 1975, a total of $11,189,000 was available for manpower initiatives. These funds are used to provide training programs leading to more efficient utilization of all types of health personnel and encourage interdisciplinary efforts to provide high quality health care in a cost-effective manner. The program also includes projects to train health professions students in the use of the team approach to the delivery of primary health care. The President's 1976 budget includes $14,400,000 for continuation of projects for primary care residencies relating to geographic and speciality maldistribution and to the recruitment and retention of the disadvantaged in health careers. Also, grants will be awarded to train health professions students in the use of the team approach to the delivery of primary health care.

Special health career opportunity grants (SHCOG) -- The special health career opportunity grants are directed toward motivating, recruiting and retaining students in schools of medicine, dentistry, osteopathy, optometry, podiatry, pharmacy, veterinary medicine, public health or other health training.

The program deals with students (1) who are likely to practice in severe shortage areas, and (2) who, due to socioeconomic factors, are financially or otherwise disadvantaged. Specifically, these awards will be made to public or nonprofit private health or educational entities to assist in meeting the cost of projects to: (1) identify, recruit and offer secondary and post-secondary education and training for increased enrollment and retention of individuals with an interest and potential for education and training in the health professions, and (2) recruit and offer admissions and retention programs for disadvantaged students already enrolled in health professions schools.

In 1975, the SHCOG program funded 9 continuation and approximately 53 new projects. In 1976, the 9,686,000 total will continue to support these projects and will support approximately 14 new projects. In 1976, the program will focus on the pre-admissions and health scholarship professional school scholarship program for the ethnic minority and socioeconomically disadvantaged student which was proposed in the Health Manpower Bill of 1974. This scholarship program is to be established for the disadvantaged enrolled in pre and post-baccalaureate programs and will provide financial assistance for students in pre-admission programs (final two-year of baccalaureate training or equivalent) and in their entry years in a health professional school (first two years of health professional training or equivalent.)

The Physician Opportunity project, Project '75, under the sponsorship of the National Medical Association (NMA) serves as a vehicle to encourage and sustain interest in medicien among minority students. The program was originally funded by the Office of Economic Opportunity (OEO) in July 1970. The funding was an outgrowth from a task force created by the inter-association committee on expanding opportunities in medicine for black and other minority students. The outcome of the task force was to increase by 12 percent the minority enrollment in the United States medical schools by 1975.

Project '75 provides information to minority students about student loan programs, scholarships, tuition stipends, and other financial support mechanisms available to assist the student in underwriting the cost of higher education. This program will be phased out in 1976.

Health Facilities Construction

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	---	---	---	---	---	---
Other expenses.....	---	$233,358,000	---	$3,000,000	-	-$230,358,000
Total.....	---	233,358,000	---	3,000,000	---	-230,358,000
(Total Budget Authority).....		(116,000,000)		(3,000,000)		(-113,000,000)
Construction grants.....		233,058,000		---		-233,058,000
Interest subsidies.....		300,000		3,000,000		+2,700,000
Total.....		233,358,000		3,000,000		-230,358,000

Construction assistance is provided in the form of matching grants, interest subsidies and loan guarantees. The last two forms, available only to private non-profit institutions, allow the government to provide a loan guarantee of up to ninety percent of the eligible cost of construction and to pay to lending institutions amounts that would reduce the interest rate paid by the school up to three percent.

Health Teaching Facilities Construction Grants

Through this matching grant program, Federal assistance has been provided in the construction of teaching and related library, clinical, and research training facilities for the training of physicians, dentists, nurses, pharmacists, optometrists, podiatrists, veterinarians, and professional health personnel.

The $233,058,000 from prior year funds will assist (in 1975) in the construction of approximately 100 projects at health professions schools and approximately sixty to sixty-five nursing school projects. In 1976, no new grant funds are being requested, however, the legislative proposal provides for loan guarantee and interest subsidy which will be available to assist schools in replacing present facilities.

Health Teaching Facilities Interest Subsidies

For 1976, the Federal Government will continue to support construction for health profession education and nursing through loan guarantees through which the Government has the authority to guarantee up to ninety percent of the principal of a loan made to a private school for construction costs that would be eligible for a construction grant.

Under the current authority the government may pay to the lending institutions an interest subsidy, on behalf of the school, amounts which would reduce the new effective interest rate paid by the school by up to three percent. Three million dollars is requested in 1976 to make payments related to projects for which funds were first committed in 1973. The total construction value of these projects will be approximately $198,000,000.

Program Management

	1975		1976		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	1,600	$34,811,000	1,600	$38,262,000	---	+$3,451,000
Other expenses	---	14,056,000	---	13,631,000	---	-425,000
Total	1,600	48,867,000	1,600	51,893,000	---	+3,026,000
(Total Budget authority)		(48,281,000)		(51,851,000)		(+3,570,000)

In 1974, several of the resource related programs formerly carried out under the Health Services and Mental Health Administration and the Bureau of Health Manpower Education, National Institutes of Health, were consolidated to form the Health Resources Administration (HRA).

Concurrent with this reorganization was a restructuring of the budget which provided that the salaries and expenses of all of the Federal operations and management personnel associated with HRA programs appear under the budget activity "Program Management." In terms of specific activities supported, approximately 80 percent of the funds requested under this segment of the budget support HRA operating personnel with the remaining 20 percent of the funds supporting overhead program direction and the Office of the Administrator staff. The agency operating personnel review and process the grants and contracts which are funded by the various programs of the HRA, provide technical assistance to regional offices and others, as well as provide national leadership to their specific areas of expertise and focus.

In addition to actual operating staff, the "Program Management" activity includes program and administrative support, planning as well as responsibility for the appraisal and evaluation of the effectiveness of health resources programs. As indicated in the table below, this segment of the "Program Management" budget amounts to about 20 percent of the total direct operations budget and includes the program direction activities of the statistics program as well as the Office of the Administrator. Also, included is the Office of Health Resources Opportunity which operates within the agency to promote and increase the access and opportunity for disadvantaged Americans to receive benefits from all agency programs.

51-805 O - 75 -- 53

This budget requests 1,600 positions and $51,851,000 for carrying out in 1976 activities associated with "Program Management." This amount includes an increase of $4,794,000 for mandatory costs such as annualization of pay raises, FTS, postage and telephone charges, one additional day of pay, and increased costs for rent and other services. Also included is $2,856,000 for the annualization of the new positions associated with the 1975 Planning Supplemental budget. This increase is offset, in part, by a $1,768,000 decrease in non-recurring equipment and contract costs.

During 1976, the major thrust of the HRA program staffs will be preparation for implementation of the several new legislative programs all of which have been or are expected to be enacted late in 1975. These programs include those carried out under the Health Services Research, Health Statistics, and Medical Libraries Act of 1974; the National Health Planning and Resources Development Act of 1974; and the health manpower legislation which is expected to be forthcoming in the spring of 1976.

Distribution of Program Management Positions and Dollars by Activity

	1975		1976 Estimate	
	Positions	Amount	Positions	Amount
National health statistics.....	44	$1,019,000	44	$1,017,000
Health planning and resources development.....	460	10,224,000	460	13,090,000
Health services research.....	224	5,575,000	224	6,344,000
Health manpower.....	619	24,520,000	619	23,930,000
Health facilities construction*.....	--	---	--	---
Office of the Administrator.....	253	7,529,000	253	7,512,000
Total **.....	1,600	48,867,000	1,600	51,893,000

* The staffs associated with this activity are distributed among the Health planning and resources development and the Health manpower programs.

** Includes $42,000 in obligations from the Social Security Trust Fund.

HEALTH RESOURCES ADMINISTRATION

National Center for Health Statistics

Program Purpose and Accomplishments

Activity: National health statistics (Public Health Service Act, Section 308)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
478	$21,997,000	$30,000,000	478	$25,636,000

Purpose: This activity provides for the collection, analysis, and publication of national, descriptive, baseline health statistics through the operation of a number of national systems; annual collection of national vital statistics on births, deaths, fetal deaths, marriages, and divorces; surveys based on sample of the birth and death records; a continuing nationwide survey of households by means of interviews; a series of national surveys based on physical examinations of samples of the population; periodic surveys of institutions and their patients or residents; a continuous sampling of short-stay hospital records; surveys of various categories of health manpower based on license renewals, reports from establishments and other sources; a national survey of physicians, practices securing data on diagnosis and treatment provided; a system of reporting family planning services; a nutrition component of the examination survey producing data on the nutritional status of the population; a continuing survey of women of child-bearing age to produce data on family planning practices, child-bearing patterns, and population growth; and a cooperative system of data collection with States and local areas for producing comparable and uniform health information and statistics at the Federal, State and local levels for planning, management, and evaluation of health programs.

Explanation: The statistical information developed within the activity deals primarily with the provision of accurate, timely and quality base-line health statistics on vital events; the health status of the population including physical, mental, and physiological characteristics of the population; illness; injury; impairment; the supply and utilization of health facilities; the supply, distribution, production, and socio-demographic characteristics of health manpower; and on changes in the health status of the population. These data are made available to a wide range of users of such statistics for the formulation of national health policies, planning, management, and evaluation of health programs at the various governmental levels, and in the private sector.

Accomplishments in 1975: During this year, the National Center for Health Statistics administered and operated the continuous and periodic health and vital statistics activities described above. A pilot Health Interview Survey project designed to develop the methodology needed to accurately measure utilization of health care and the total expenditures involved in obtaining the care was launched.

Data were gathered on the use of oral drugs and insulin by diabetics. A second report on nutrition in the United States was published. In the area of health care utilization the Center published preliminary reports from the first national survey of nursing homes directed at producing data on the costs and quality of care in these institutions, published data from the first survey of patients seen in physicians' offices, prepared a report on the methodology of the family planning reporting system which processes annually some five million records of patient visits; and conducted a national conference which developed a minimum basic data set on long-term care.

The field work for the first biennial National Survey of Family Growth was completed and data tapes processed. The Center worked with thirty-nine State and local areas which were participating in one or more components of the Cooperative Health Statistics System, and with four States with research and developmental agreements and as the major health statistical organization in the United States, the Center provided consultation and assistance in international health statistical activities. During 1975 the Center met twelve requests for consultation by the World Health Organization and other international bodies, including development of the United States position and input into the next revision of the International Classification of Diseases. The Center also responded to official requests from six foreign countries for technical assistance in health survey methods, vital statistics registration and other statistical techniques. During the year, thirty-five visits were made to the Center by researchers, dignitaries, and health statisticians from nineteen countries. Project direction was provided for twelve research projects in five countries under the Special Foreign Currencies Program (formerly P.L. 480). In addition, the Center was active in planning management for the first meeting of the new United States National Committee on Vital and Health Statistics. This committee was created by statutory authority of Public Law 93-353 to assist and advise the Secretary of the Department on national and international health statistics problems.

Objectives for 1976: The major objective to be pursued during 1976 with the requested funding increase will be to continue the development of the Cooperative Health Statistics System by funding the Federal share of State data collection systems, supporting developmental projects undertaken by the States, and providing technical assistance to the States. It is estimated that in 1976 the number of States providing vital statistics data will be increased from nine to fifteen; health facilities data from five to twelve; and hospital care data from two to five. An additional fifteen to twenty States will be funded in a developmental stage.

HEALTH RESOURCES ADMINISTRATION

Health Planning and Resources Development

Program Purpose and Accomplishments

Activity: Health planning and resources development (Public Health Service Act, Titles XV and XVI, Social Security Act, section 1122)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$127,839,000*	$338,000,000 Indefinite	---	$166,000,000
(Obligations:)	(221,454,000)	-- -		(205,266,000)

*1975 Planning Supplemental request is $60,900,000.

Purpose: To implement the programs set forth in the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

Explanation: The National Health Planning and Resources Development Act of 1974 redirects, expands and coordinates Federal, State and local health planning and development efforts. The Health Planning and Resources Development Program (HP&RD) retains certain aspects of the preceding planning programs, (i.e., CHP, RMP, Hill-Burton & EHSDS) including a system of State and local agencies which plan for the health needs of their communities and review requests for Federal funds for new health services or facilities against these plans. The HP&RD program also contains new elements such as a program of planning methods development to develop the art of health planning and to provide the State and local planning agencies with effective planning tools and technical assistance.

Accomplishments in 1975: During the first six months of 1975 the several existing Federal health planning and resource development programs, including CHP, RMP, EHSDS and the Hill-Burton programs, were supported by a continuing resolution, by 1973 and 1974 appropriated funds still available for obligation, and/or by released 1973 funds. The authorizing legislation for these programs had expired June 30, 1974.

On January 4, 1975, the National Health Planning and Resources Development Act of 1974 was signed into law. The last six months of 1975 were spent initiating the implementation of the new programs required in this legislation. The request to begin implementation of the new program in 1975 was $60,900,000. An additional $8,500,000 for Section 1122 capital expenditure review and $5,600,000 for program management were also included in the overall $75,000,000 request for the new program. These funds supported the following activities:

a) One-half (28) of the State Health Planning and Resource Development Agencies were designated and funded by June 30, 1975, at a cost of $9,500,000.

b) The area designation process was nearing completion (projected to be finished by August 1, 1975) by the end of 1975.

c) The State and local CHP's, RMP's, EHSDS's and Hill-Burton agencies, supported with transition funds under the new legislation, were completing old programs and, where appropriate, preparing to become a part of the new health planning and resources development system. These activities cost $42,200,000.

d) Thirty grants and contracts were used to initiate the development of health planning methods in 1975 at a total cost of $7,000,000. During this first year the overall emphasis was on assisting the new planning agencies to perform the planning functions required by the new law.

e) A total of $2,200,000 was awarded in 1975 for the provision of technical assistance to HP&RD grant applicants.

f) Construction funds available from prior year appropriations supported new and ongoing projects for the modernization or construction of medical facilities. Of 86 new projects initially approved during the first six months of 1975: thirty-two were for general hospitals; twenty-eight for outpatient facilities; nine for long-term care facilities; seven for rehabilitation facilities; and ten for public health centers.

Objectives in 1976: A total of $166,000,000 is requested to continue the implementation of the new HP&RD program. This amount includes $45,000,000 to support the two hundred new HSAs; $500,000 for technical assistance to HP&RD grant applicants; $9,500,000 to support the first-year costs of the twenty eight remaining new State agencies yet to be designated; $7,000,000 for the planning methods development program; $100,000,000 for medical facilities construction and $4,000,000 for Section 1122 transition activities.

HEALTH RESOURCES ADMINISTRATION

Health Services Research

Program Purpose and Accomplishments

Activity: Health services research (Public Health Service Act, Section 308)

1975 Estimate		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
18	$35,905,000	$80,000,000	18	$26,000,000
(Obligations:)	(42,572,000)			(26,000,000)

Purpose: The National Center for Health Services Research conducts research to improve the organization, delivery, quality, and financing of health services.

Explanation: The research programs of the National Center are carried out through research, evaluation and demonstrations. The research effort will involve a combination of intramural and extramural activities, including studies to be carried out by the Health Services Research Centers.

Accomplishments in 1975: In 1975, the National Center directed its efforts to activities which would improve knowledge of the health services delivery system; moderate rising costs and increase access to productive and effective health services. Special emphasis was placed on quality assessment research, impact of inflation studies, and insurance plans-related research.

Objectives for 1976: The 1976 budget request for the Health Services Research activity includes a total of $26,000,000, a decrease of $9,905,000 from the 1975 level. Of the $26,000,000, $9,000,000 is available for the support of new research grants and contracts, including an estimated $4,000,000 to support the establishment of six Health Services Research Centers required under Section 305(d) of the Public Health Service Act.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Health professions support--institutional assistance (Public Health Service Act, Title VII, Part E)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$167,200,000	1/	--	$109,100,000
(Obligations:)	(175,154,000)			(109,100,000)

1/ Proposed legislation pending.

Purpose: To provide support to health professions schools for establishing and maintaining a viable financial base and for maintaining enrollments.

Explanation: The four institutional assistance grant programs are:

1. Capitation: A complex formula grant, which includes in its computation class size, total enrollments, and number of graduates to provide basic Federal support to the educational programs of the Medicine, Dentistry, and Osteopathy, Optometry, Podiatry, Pharmacy and Veterinary medicine.

2. Start-up and Conversion: Under this activity, grants are awarded to new schools of medicine, osteopathy and dentistry in the year preceding the enrollment of students and in each of the next three years in order that the schools may begin earlier or to substantially increase enrollment.

3. Financial Distress: Awards under this activity are to schools which have demonstrated critical financial need and which also plan management improvement activities to overcome reliance on this Federal support.

4. D.C. Medical/Dental Educational Assistance: Awards under this activity are to private medical and dental schools in the District of Columbia which have demonstrated critical financial need but which also plan management improvement activities to overcome continued reliance on this form of support.

Accomplishments in 1975:

1. Capitation: These basic educational grants were awarded to all eligible health professions schools which provide enrollment and fiscal resource assurance. About 300 schools of medicine, osteopathy, dentistry, optometry, podiatry, pharmacy, and veterinary medicine participated.

2. Start-up and Conversion: Grants totalling $4,700,000 were awarded to ten schools initially receiving support in prior years.

3. Financial Distress: Approximately 15 schools were assisted which demonstrated critical current financial need. Schools aided by these grants conducted appropriate activities to alleviate their financial dependency on these grants, and improve their own fiscal and management operations.

4. D.C. Medical/Dental Educational Assistance: The $7,500,000 supported George Washington University School of Medicine and Georgetown University Schools of Medicine and Dentistry.

Objectives for 1976: The capitation request of $101,100,000 continues basic support to approximately 300 schools of medicine, osteopathy, dentistry, optometry, podiatry, and veterinary medicine. Five schools now supported through the start-up grant program will receive continuation grants and approximately four new schools will receive awards in 1976 totalling $3,000,000. The $5,000,000 requested for financial distress grants will provide support to 12 health profession schools.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Health professions--student assistance (Public Health Service Act, Title II and Title VII, Parts C and F)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$66,354,000	1/	--	$52,000,000

1/ Proposed legislation pending.

Purpose: The program of student assistance provides loans and scholarships to eligible students who need financial assistance in order to pursue a career in the health professions. The National Health Service Scholarship program provides financial assistance to eligible students in return for a commitment of future health service. The Loan Repayment program provides for the repayment of outstanding educational loans for students who agree to practive in a shortage area.

Explanation: The loan and scholarship funds are awarded to schools based on legislative formulas. The school in turn awards funds in accordance with individual student needs after considering other available financial resources. The National Health Service Scholarships are awarded to students on an annual basis in the form of scholarship stipends and the payment of tuition and educational fees in return for a future commitment to serve as a Commissioned Officer, a civilian member of the National Health Service Corp, or serve in a designated health manpower shortage area. The Loan Repayment program encourages students to enter into the National Health Service Corp or practice in a shortage area in their profession for at least 2 years in return for loan repayments of up to 85% of all educational loans.

Accomplishments in 1975: The participating health professions schools made loans to about 27,450 students totalling $33,954,000 and scholarships to over 8,000 students totalling $6,900,000. The National Health Service Scholarship program supported 391 continuation applicants and 1850 new participants for a total of $22,500,000. The Loan Repayment program supported approximately 650 applicants totalling $3,000,000.

Objectives in 1976: Both health professions loan and scholarship funds will be used for continued support to those students who previously received assistance under these programs. Though this particular direct loan program is

being phased out, the student loan guarantee program in the Office of Education will be expanded. Also the National Health Service Scholarship and Loan Repayments programs will be utilized to a greater degree. Accordingly, $23,500,000 in loan and scholarship funds is requested to provide phase-out assistance to approximately 20,000 students. In addition, $22,500,000 is requested to support approximately 2,300 students in the National Health Service Scholarship program. An expanded and improved Loan Repayment program will be available to students in financial need; $6,000,000 is requested to support some 1,300 students.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Health professions--dental health activities (Public Health Service Act, Sections 301 and 774)

1975			1976		
				Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$7,842,000	Indefinite/1/	---	$7,842,000

1/ Proposed legislation pending.

Purpose: This activity provides the Federal focus for dental education, practice, and manpower and service research.

Explanation: The dental health program conducts and provides contract support for a broad array of research, development and demonstration projects and provides technical assistance and consultation to activities and programs designed to improve the distribution, supply, utilization, and productivity of dental manpower resources; to improve the quality, effectiveness, and efficiency of educational resources for training dental personnel; to improve the organization, operation, and effectiveness of dental delivery systems. The Training in Expanded Auxiliary Management (TEAM) grants program provides support to dental schools to develop programs to train dental students to manage a dental team which includes one or more expanded function auxiliaries who provide patient services which heretofore have been performed solely by the dentist.

Accomplishments in 1975: Twenty-six dental schools received continued support in TEAM and three new programs were funded totalling $5,188,000. In addition, a national evaluation of TEAM and Expanded Auxiliary Training programs was initiated to examine the cost-effectiveness of funded programs. Approximately $200,000 will be used to support 6 dental continuing education programs. Research and development, demonstration and educational assistance programs were supported by about 29 contracts and 5 agreements totalling $2,454,000 The register of licensed dentists and dental hygienists was updated and efforts begun to assess the methods for gathering all-basic dental manpower data.

Objectives in 1976: Cost-effectiveness of the TEAM grant program will be improved by implementing the results of evaluation projects funded in 1975, e.g., increasing the percent of students trained in each school and decreasing the number of clinic hours. The impact of TEAM will be evaluated by initiating a study of those students trained in TEAM who are now in private practice. Criteria including that provided by the dental profession will be developed and utilized in the identification of dental manpower shortage areas.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Nursing support-institutional assistance (Public Health Service Act, Title VIII, Part A)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$39,093,000	1/	---	---

1/ Legislation expired on June 30, 1974

Purpose: This activity provides financial assistance to nursing educational institutions to improve the quality of nursing education and to prepare the numbers and types of nurses needed to provide nursing care for the health delivery system.

Explanation:

1. Capitation grants -- These annual grants are based on statutory formula to eligible nursing education programs that expand enrollments and prepare specialized nurse practitioners.

2. Financial distress grants -- These grants are awarded for a period of one year to assist schools of nursing which are in serious financial condition to regain fiscal stability and to meet operational costs required to maintain quality educational programs, or which have special need for financial assistance to meet accreditation requirements.

Accomplishments in 1975: Approximately 981 capitation awards were made totalling $33,343,000 to support an enrollment of approximately 181,200. Financial distress grants supported approximately 60 schools, with a total enrollment of about 11,160, in need of financial aid.

Objectives for 1976: Funds are not being requested for these programs.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Nursing--student assistance (Public Health Service Act, Title VIII, Parts B and D)

1975			1976	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$41,916,000	1/	---	$15,500,000

1/ Proposed legislation pending.

Purpose: The nursing student loan and scholarship programs provide financial aid to needy students, particularly those from disadvantaged and minority groups. The traineeships program assists registered nurses to obtain the necessary knowledge and skills to become academically prepared for positions as teachers, administrators, supervisors and clinical specialists. These grants cover costs of tuition, stipends, and dependency allowances. The Loan Repayment program provides for the repayment of outstanding educational loans for students who agree to practice in a shortage area and for those who are financially disadvantaged.

Explanation: Loan and scholarship funds are awarded to participating schools of nursing on the basis of statutory formulas. The schools in turn award funds to students on the basis of individual needs and resources. Traineeships are awarded to participating schools which select trainees according to their individual needs. The Loan Repayment program provides repayment of education loans up to 85 percent to nurses who agree to serve in a shortage area or who fail to complete their education and are financially disadvantaged.

Accomplishments in 1975: The nursing loan program assisted 28,500 students with the $22,800,000 appropriated. Continued assistance, on a phase-out basis, was provided to 6,000 scholarship recipients, totalling $6,000,000. Nurse traineeships supported approximately 3,000 trainees ($4,300 per trainee) at about 136 schools totalling $13,016,000. The nurse loan repayment program assisted approximately 40 students for $100,000.

Objectives for 1976: The request for 1976 of $9,000,000 will provide continued support of loans for an estimated 11,250 nursing students. Continued scholarships support totalling $4,000,000 will be provided to approximately 4,000 students who were prior recipients of scholarship awards. Future scholarship awards will be made through programs with a service commitment or through the expanded Basic Opportunity Grants program in the Office of Education. No funds are requested for the traineeship program. Students needing this type of assistance will have access to the Guaranteed Loan program in the Office of Education. The loan repayment program, totalling $2,500,000 will assist about 1,000 students.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Public health support--(Public Health Service Act, Title III, Part A)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$20,520,000	1/	---	---

1/ Legislation expired on June 30, 1974.

Purpose: This program provided Federal assistance to schools of public health to assist those schools in providing training and technical assistance in public health programs, and for project grant support to a variety of institutions, including schools of public health, medicine, dentistry, nursing, and programs in health administration to improve and expand graduate programs in public health. Traineeship grants were awarded competitively to the institutions which then had responsibility for the selection and appointment of individual trainees.

Explanation: Grants to schools of public health were awarded on a formula basis, and project grants on a competitive basis. Traineeship grants were awarded competitively to the institutions which then had responsibility for the selection and appointment of individual trainees.

Accomplishments in 1975: The graduate programs in Public Health supported approximately 57 projects totalling $5,700,000. Public Health formula grants were awarded to 18 schools in the amount of $5,700,000 at about $316,000 per school. Approximately 344 public health traineeships were awarded, of which 194 were long-term and 150 short-term. These traineeships assisted approximately 11,830 trainees.

Objectives for 1976: No funds are requested for these programs.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Allied health support--(Public Health Service Act, Title VII, Part G, Section 792 b and c)

1975			1976	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$33,821,000	1/	---	---

1/ Legislation expired on June 30, 1974

Purpose: Special improvement grants were awarded to allied health training centers to assist in the provision, maintenance, or improvement of the specialized functions which these centers serve. Special projects support experimentation, demonstration, and institutional improvement in allied health training. Traineeship grants for advanced training were awarded to support students preparing to teach or to serve in administrative, supervisory or specialist capacities in allied health disciplines. Grants were for long-term academic training, usually leading to the master's degree, and short courses designed to improve the teaching, administrative and supervisory capabilities of currently employed allied health professionals.

Explanation: Special improvement grants are awarded to junior colleges, colleges, and universities for curriculum improvement and expansion of enrollment capacity. Special projects complement the resources of the more output-oriented special improvement grants, by providing support for experimentation and innovation. Traineeship grants are awarded competively to agencies, institutions, and organizations that provide the appropriate training. Selection and appointment of individual trainees is the responsibility of the training institution.

Accomplishments in 1975: Special improvement grants (320) were awarded totalling $16,000,000. Allied Health Special Projects supported about 92 projects for the development of models for coordination of educational programs and credentialing in the allied health professions. Special projects also continued the support of about 45 projects under the OPERATION MEDIHC program which assisted in the placement of 5,500 veterans. The traineeship program assisted 5,050 trainees.

Objectives for 1976: No funds have been requested for these programs.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Program Purpose and Accomplishments

Activity: Special education programs (Public Health Service Act, section 301, Title VII and VIII.)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$104,558,000	1/	--	$154,558,000

1/ Legislation expired on June 30, 1974 - Proposed legislation pending.

Purpose: These programs are designed to improve the distribution, supply, quality, utilization, and efficiency of health personnel and the health service delivery system, to link health manpower education programs to the health service delivery system in the establishment of Area Health Education Centers (AHEC); the training of physicians' assistants to provide primary health care in medically underserved areas; to expand the functions of the dental auxiliaries; encouraging local, State and regional initiatives in overcoming geographic and specialty maldistribution of health manpower; improving access to primary health care by large urban and rural population groups through efficient utilization of health manpower; to train doctors in family medicine and primary care residenceships; to increase admissions in schools providing training for individuals likely to practice their health profession in rural or other areas having a severe shortage of personnel in such health professions; and to identify disadvantaged individuals with potential for education or training in the health professions and encouraging and assisting them to enroll in a school providing health training.

Explanation: Contracts and grants under both section 767 and 774 support flexible short-term programs and family medicine grants to public or non-profit hospitals to plan, develop, and operate training programs. Special projects grants and contracts for health professions and nursing provide a program of targeted activities which include support for correcting specialty and geographic maldistribution, expanding training in primary care and family medicine, increasing admission of the disadvantaged, and improving nurse training and services including the preparation of specialized nurse practitioners.

Accomplishments in 1975: Under the health professions special projects program, approximately 176 continuation grants were provided to schools for the physician augmentation programs for expanding training in primary care and for other purposes authorized under the law. Family medicine grants were awarded to

51-805 O - 75 -- 54

approximately 73 hospitals to support programs training about 1,500 residents. Forty physicians' assistant training programs with approximately 2,000 students enrolled were supported. The expanded function dental auxiliary program supported approximately 13 programs to train about 200 instructors and 500 auxiliaries. Approximately 210 nursing special projects for demonstration, innovation, and implementation of programs to develop and incorporate new knowledge into nursing curricula and practice were supported. Eleven Area Health Education Center programs totalling $12,000,000 were supported which provided clinical education for medical, dental, nursing, and various allied health manpower students at 27 AHEC sites. Approximately 7,400 medical, dental, nursing and allied health students participated in these training programs. About 490 residents participated in AHEC residency training programs. A total of $11,189,000 was available for manpower initiatives to support 28 new and 13 continuation projects for the disadvantaged, maldistribution analysis and recruitment of disadvantaged into health careers, and for initiatives related to training students in primary care in underserved areas. The special health career opportunity grant program supported 9 continuation programs and approximately 53 new programs totalling $6,686,000.

Objectives for 1976: The majority of the $45,472,000 requested in 1976 for health professions special projects will be used for continuation support of previous activities. Funds will also be used to support new programs in primary care, inter-disciplinary training and other related purposes. The family medicine request for 1976 is $27,000,000 and is expected to support 73 continuation projects and 92 new projects. The primary care residency program totalling $12,000,000 will initiate 48 new programs offering 290 residency years of instruction. The $12,000,000 for the physicians' assistant programs will provide support for 40 continuation and 23 new programs with an enrollment of 3,100 students and 13 continuation and 10 new expanded function of dental auxiliary programs. The $18,000,000 requested in 1976 for nursing special projects will support approximately 110 continuing and 38 new grants and contracts. Priority areas include consortia for continuing education, development of specialized curricula, and primary care programs. The estimate of $16,000,000 for the AHEC program will provide for the fourth year continuation of the 11 AHEC projects. The request for manpower initiatives is $14,400,000 to support continuation programs in primary care residencies relating to the problems of geographic and specialty maldistribution, recruitment and retention of the disadvantaged, and training of students in the delivery of primary health care. Under the special health career opportunity program, $9,686,000 will continue the present programs as well as support approximately 14 new projects.

HEALTH RESOURCES ADMINISTRATION

Health Facilities Construction

Program Purpose and Accomplishments

Activity: Health teaching facilities-- construction grants (Public Health Service Act, Title VII, Part B, and Title VIII, Part A)

1975		1976		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$114,000,000	1/	---	---
	(Obligations:) (233,058,000)			(---)

1 Legislation expired June 30, 1974.

Purpose: Assistance is authorized for Federal participation in the construction of teaching and related library, clinical, and research facilities for the training of physicians, dentists, nurses, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.

Explanation: Construction assistance is provided in the form of matching grants.

Accomplishments in 1975: Grant awards for construction of facilities at health professions schools totaling approximately $197,500,000 and $35,558,000 for schools of nursing were made in 1975 with funds available from prior years and 1975. These funds supported approximately 100 projects at the health professions schools and approximately 60 to 65 nursing school projects.

Objectives for 1976: No extension of grant authority for construction of health teaching facilities is being requested. Projects initiated under prior year awards will be monitored to completion.

HEALTH RESOURCES ADMINISTRATION

Health Facilities Construction

Program Purpose and Accomplishments

Activity: Health teaching facilities-- interest subsidies (Public Health Service Act, Title VII, Part B, and Title VIII, Part A)

1975			1976	
				Budget Estimate
Pos.	Amount	Authorization	Pos.	Amount
---	$2,000,000	1/	---	$3,000,000
	(Obligations:)			
	(300,000)			(3,000,000)

1/ Legislation expired June 30, 1974, proposed legislation pending.

Purpose: Assistance is authorized for Federal participation in the construction of teaching and related library, clinical, and research facilities for the training of physicians, dentists, nurses, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.

Explanation: The loan guarantees with interest subsidy, which are available only to private non-profit entities, allows the Government to provide a loan guarantee of up to ninety percent of the eligible cost of construction and to pay to lending institutions amounts that would reduce the interest rate paid by the schools by as much as three percent.

Accomplishments in 1975: Interest subsidy payments estimated at $300,000 were made in 1975 against projects for which commitments had been made.

Objectives for 1976: The amount of $3,000,000 is requested for interest subsidy payments on projects for the construction of facilities at schools of health professions and nursing. This will provide for the continuation of support to the projects which received interest subsidy commitments in prior years. The total construction costs for these projects will be approximately $198,000,000.

HEALTH RESOURCES ADMINISTRATION

Program Management

Program Purpose and Accomplishments

Activity: Program management (Public Health Service Act, Titles III, VII, VIII, XV, XVI, Section 225, and Social Security Act, Section 1122)

1975 Estimate			1976	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
1600	$48,281,000	Inherently Authorized	1600	$51,851,000
(Obligations:)	(48,867,000)			(51,893,000)

Purpose: This activity supports the salaries and expenses of the Federal extramural operations and management personnel associated with the Health Resources Administration programs.

Explanation: This activity provides the funds for maintaining the operations and staff of the Health Manpower, Health Services Research and the Health Planning and Resources Development extramural programs; the Office of the Administrator; and the program direction activities of the National Center for Health Statistics.

Accomplishments in 1975: In addition to performing the review and processing of the grants and contracts which are supported by programs of the HRA and the provision of technical assistance to grantees and contractors, major staff efforts involved support to the development of the major pieces of HRA related legislation as well as the analysis of program impact and redirection.

Objectives for 1976: During 1976, the major thrust of the HRA program staffs will be the preparation for implementation of the several new legislative programs all of which have been or are expected to be enacted late in 1975. These programs include those carried out under the Health Services Research, Health Statistics, and Medical Libraries Act of 1974; the National Health Planning and Resources Development Act of 1974; and the health manpower legislation which is expected to be forthcoming in the spring of 1975.

This budget requests 1,600 positions and $51,851,000 for carrying out, in 1976, activities associated with "Program Management." This amount includes a $4,794,000 increase for mandatory costs of which $2,856,000 is for the annualization of the new positions associated with the 1975 Planning Supplemental budget. This increase is offset by a $1,768,000 decrease in non-recurring equipment and contract costs.

TENTATIVE FY 1976 HEALTH FACILITIES CONSTRUCTION GRANT ALLOTMENTS AND MINIMUM ALLOTMENTS FOR OUTPATIENT FACILITIES UNDER P.L. 93-641

State	Total Allotments	Outpatient Minimum	State	Total Allotments	Outpatient Minimum
Total	$78,000,000	$19,500,000			
Alabama	1,000,000	250,000	New Jersey	2,698,894	674,724
Alaska	1,000,000	250,000	New Mexico	1,000,000	250,000
Arizona	1,000,000	250,000	New York	5,265,558	1,316,390
Arkansas	1,000,000	250,000	North Carolina	1,730,585	432,646
California	4,024,568	1,006,142	North Dakota	1,000,000	250,000
Colorado	1,000,000	250,000	Ohio	2,515,037	628,759
Connecticut	1,000,000	250,000	Oklahoma	1,000,000	250,000
Delaware	1,000,000	250,000	Oregon	1,000,000	250,000
Dist. of Col.	1,000,000	250,000	Pennsylvania	3,909,428	977,357
Florida	1,666,303	416,576	Rhode Island	1,000,000	250,000
Georgia	1,236,495	309,124	South Carolina	1,000,000	250,000
Hawaii	1,000,000	250,000	South Dakota	1,000,000	250,000
Idaho	1,000,000	250,000	Tennessee	1,365,769	341,442
Illinois	2,883,697	720,924	Texas	3,068,086	767,022
Indiana	1,588,361	397,090	Utah	1,000,000	250,000
Iowa	1,075,111	268,778	Vermont	1,000,000	250,000
Kansas	1,000,000	250,000	Virginia	1,437,857	359,464
Kentucky	1,000,000	250,000	Washington	1,000,000	250,000
Louisiana	1,317,513	329,378	West Virginia	1,000,000	250,000
Maine	1,000,000	250,000	Wisconsin	1,100,894	275,224
			Wyoming	1,000,000	250,000
Maryland	1,000,000	250,000			
Massachusetts	2,028,754	507,188	American Samoa	500,000	125,000
Michigan	2,274,054	568,514	Guam	500,000	125,000
Minnesota	1,221,889	305,472	Puerto Rico	1,248,737	312,184
Mississippi	1,000,000	250,000	Trust Territory	500,000	125,000
			Virgin Islands	500,000	125,000
Missouri	1,342,410	335,602			
Montana	1,000,000	250,000			
Nebraska	1,000,000	250,000			
Nevada	1,000,000	250,000			
New Hampshire	1,000,000	250,000			

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Amounts Available for Obligation

	1976 Estimate	1976 Interim Period
Appropriation	$611,487,000	$135,290,000
Receipts and reimbursements from:		
"Social Security Trust Fund"	42,000	11,000
Unobligated balance, start of year	135,936,000	96,670,000
Unobligated balance, end of year	-96,670,000	-91,045,000
Total, obligations	650,795,000	140,926,000

Obligations by Activity

Page Ref.		1976 Estimate Pos.	1976 Estimate Amount	1976 Interim Period Pos.	1976 Interim Period Amount
	National health statistics	478	$25,636,000	478	$6,500,000 A/
	Health planning and resources development:				
	a) Health planning grants and contracts	---	66,000,000	---	16,625,000 B/
	b) Construction grants	---	139,266,000	---	5,625,000 C/
	(Budget Authority)		(100,000,000)		(---)
	Health services research	18	26,000,000	18	2,500,000 D/
	Health manpower:				
	a) Health professions institutional assistance:				
	1) Capitation grants	---	101,100,000	---	---
	2) Start-up and conversion grants	---	3,000,000	---	---
	3) Financial distress grants	---	5,000,000	---	---
	b) Health professions student assistance:				
	1) Loans	---	20,000,000	---	20,000,000 E/
	2) Scholarships	---	3,500,000	---	3,500,000 F/
	3) Loan repayments	---	6,000,000	---	2,000,000 G/
	4) National health service scholarships	---	22,500,000	---	22,500,000 H/
	c) Dental health activities	---	7,842,000	---	2,000,000 J/
	d) Nursing student assistance:				
	1) Loans	---	9,000,000	---	9,000,000 K/
	2) Scholarships	---	4,000,000	---	4,000,000 L/
	3) Loan repayments	---	2,500,000	---	1,000,000 M/
	e) Special educational programs:				
	1) Health professions special projects	---	45,472,000	---	10,000,000 N/
	2) Family medicine residencies	---	27,000,000	---	8,000,000 O/
	3) Primary care residencies	---	12,000,000	---	---
	4) Physicians assistants	---	12,000,000	---	3,000,000 P/
	5) Nursing special projects	---	18,000,000	---	4,000,000 Q/
	6) Area health educational centers and other initiatives	---	16,000,000	---	4,000,000 R/
	7) Manpower initiatives	---	14,400,000	---	2,000,000 S/
	8) Special health career opportunity grants	---	9,686,000	---	---
	Health teaching facilities interest subsidies	---	3,000,000	---	3,000,000 T/
	Program management	1,600	51,893,000	1,600	11,676,000 U/
	Total obligations	2,096	650,795,000	2,096	140,926,000

A/ Represents approximately one fourth of the 1976 level of support.

B/ Represents proportionate share of 1976 level to fund on-going Health Systems Agencies and methods and development contracts.

C/ Obligations reflected are against funds requested in 1976 and available through 1978.

D/ The $2,500,000 will provide for continuation funding of the intramural and extramural research program initiated in 1976 and prior years.

E/ Health professions loan funds requested to support a full academic year for the student at the 1976 level.

F/ Health professions scholarship funds requested to support a full academic year for the student at the 1976 level.

G/ Level of support needed for projects that will require continuation funds during this period.

H/ National health service scholarship funds requested to support a full academic year for the student at the 1976 level.

J/ Level of support for dental health projects that will require continuation costs during this period.

K/ Funds requested to support a full academic year for the student at the 1976 level.

L/ Funds requested to support a full academic year for the student at the 1976 level.

M/ Level of support needed for nursing loan repayments that will require continuation costs during this period.

N/ Level of support needed for health professions special projects that will require continuation funds during this period.

O/ Level of support needed for family medicine residencies projects that will require continuation costs during this period.

P/ Level of support requested for physician assistant projects that will require continuation costs during this period.

Q/ Level of support requested for nursing special projects that will need continuation costs during this period.

R/ Funds needed for area health educational centers and other initiatives projects that will require continuation costs during this period.

S/ Funds requested for manpower initiatives projects that will need continuation costs during this period.

T/ Funds are requested for health teaching interest subsidies payments that are anticipated during the three-month period.

U/ The funds requested in program management will maintain the 1976 level of support for personnel and related costs.

Obligations by Object

	1976 Estimate	1976 Interim Period
Total number of permanent positions	2,096	2,096
Full-time equivalent of all other positions	178	178
Average number of all employees	2,209	2,209
Personnel compensation:		
Permanent positions	$40,543,000	$10,308,000
Positions other than permanent	2,141,000	491,500
Other personnel compensation	469,000	114,500
Subtotal, personnel compensation	43,153,000	10,914,000
Personnel benefits	4,757,000	986,000
Travel and transportation of persons	3,457,000	648,000
Transportation of things	221,000	52,000
Rent, communications and utilities	4,141,000	746,000
Printing and reproduction	1,078,000	280,000
Other services	12,801,000	3,411,000
Project contracts	84,689,000	4,960,000
Supplies and materials	669,000	102,000
Equipment	805,000	77,000
Investments and loans	29,000,000	29,000,000
Grants, subsidies and contributions	466,024,000	89,750,000
Total obligations	650,795,000	140,926,000

Justification

Health Resources

National health statistics The $6,500,000 requested will permit the National Center for Health Statistics to maintain its data collection and related activities at the 1976 operating level. Activities utilizing services of other government agencies through interagency agreements will be extended on a pro-rata basis during this period. The request includes approximately $1,000,000 for project contracts for those surveys that will require contract extensions in this period.

Health planning and resource development A total of $16,625,000 is requested to support, during the 1976 interim period, a nationwide network of State and local health planning agencies, planning methods development and technical assistance. All 200 Health Systems Agencies (HSAs) will be initially funded for their first year costs in 1976 for a total of $45,000,000. During this interim period, the agencies funded in 1975 will require a portion of their second year funds. The 56 State health planning and resources development agencies which received initial first year funds during 1975 and 1976 will require interim period support beyond any unobligated funds available at the start of the interim period.

Effective methods for planning for health services and facilities are also in short supply. The efforts of the planning methods development program to develop such technology are also integral to the HP&RD. Both the National Center for Health Statistics and the National Center for Health Services Research are providing assistance, where applicable, in these areas.

Health services research The requested $2,500,000 will provide for continuation funding of the intramural and extramural research program initiated in 1976 and prior years. Of the estimate, $625,000 is to provide support for the intramural research staff including positions hired under the Intragovernmental Personnel Act and the Research and Service Fellows program. The remaining $1,875,000 will be used to fund non-competing grant and contract continuations, including the second year funding for the Health Services Research Centers established in September 1975.

Health manpower Funds requested in the 1976 interim budget for Health Manpower activities will total $98,000,000. An estimated $39,000,000 will be for project activities that will require continuation costs falling due within the three-month transition period.

The remaining $59,000,000 is requested for student assistance activities. These funds will be for Health Professions and Nursing loans and scholarship students and also for the National Health Service Scholarship recipients. These funds are requested for the full amount of the 1976 level. Student assistance programs are on a formula basis and are calculated for the full year and would be administratively impractical to do piece-meal. Also student assistance programs traditionally have been processed on an advance obligational authority basis in order that the schools can have a lead time in planning their programs. The $59,000,000 request would eliminate the need for advance obligational authority.

Program management The $11,676,000 requested will permit the agency to meet on-going expenses of personnel and related costs at the 1976 operating level during this interim period.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Payment of Sales Insufficiencies and Interest Losses

(Health Education Loans)

	Page No.
Appropriation Language	186
Payment of Sales Insufficiencies and Interest Losses	186
Health Education Loans	187
Amounts Available for Obligation	188
Obligations by Activity and Object	189
Summary of Changes	191
Authorizing Legislation	192
Table of Estimate and Appropriation	193
Justification	194

Appropriation Estimate

HEALTH EDUCATION LOANS

The Secretary is hereby authorized to make such expenditures, within the limits of funds available in the Health Professions Education Fund and the Nurse Training Fund, and in accord with law, and to make such contracts and commitments without regard to fiscal year limitation as provided by Section 104 of the Government Corporation Control Act, as amended, as may be necessary in carrying out the programs set forth in the budget for the current fiscal year and for the period July 1, 1976, through September 30, 1976.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Payment of Sales Insufficiencies and Interest Losses

Amounts Available for Obligation

	1975	1976
Appropriation	$4,000,000	$4,000,000
Estimated transfer to other accounts 1/	4,000,000	4,000,000
Health Professions Education Funds	(2,268,000)	(2,284,000)
Nurses Training Fund	(1,732,000)	(1,716,000)

1/ Distribution between Health Professions Education Fund and Nurse Training Fund may vary due to changing interest rate.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Health Professions Education Fund

Amounts Available for Obligation

	1975	1976
Receipts and reimbursements from non-Federal Sources	$2,600,000	$2,610,000
Transferred from other accounts (estimate)	2,268,000	2,284,000
Transferred to participation Sales Fund	-438,000	-530,000
Unobligated balance, start of year	32,156,000	31,718,000
Other unobligated balances, end of year	-31,718,000	-31,188,000
Total, obligations	$4,868,000	$4,894,000

Obligations by Activity and Object

	1975	1976	Increase or Decrease
Cancellations	$ 370,000	$ 391,000	+$21,000
Interest	4,498,000	4,503,000	+5,000
Total, Obligations	$4,868,000	4,894,000	+$26,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Nursing Training Fund

Amounts Available for Obligation

	1975	1976
Receipts and reimbursements from non-Federal Sources..	$2,189,000	$2,174,000
Transferred from other accounts (estimate).....	1,732,000	1,716,000
Transferred to participation sales fund.....	-290,000	-351,000
Unobligated balance, start of year.....	20,724,000	20,434,000
Other unobligated balances, end of year.....	-20,434,000	-20,083,000
Total Obligations.....	$3,921,000	$3,921,000

Obligations by Activity and Object

	1975	1976	Increase or Decrease
Cancellations	$ 827,000	$ 869,000	+$42,000
Interest.....	3,094,000	3,021,000	-73,000
Total Obligations.....	$3,921,000	$3,890,000	-$31,000

51-805 O - 75 -- 55

Summary of Changes

1975 Appropriation	$4,000,000
1976 Request	4,000,000
Net change	---

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Cancellations	---	$1,260,000	---	$ +63,000
Total, increases	---	---	---	+63,000
Decreases:				
A. Built-in:				
1. Payment to Treasury	---	1,811,000	---	-63,000
Total, decreases	---	---	---	-63,000
Total, net change	---	---	---	---

Explanation of Changes

Increases:

The $63,000 is needed for reimbursements to schools for estimated loan repayments cancelled under section 744(b) and 827(b) of the Public Health Service Act.

Decreases:

The decrease in interest owed to the Treasury results from a reduction in loans outstanding.

Authorizing Legislation

	1976 Authorized	1976 Appropriation Requested
Legislation:		
Public Health Service Act:		
Payments to Schools to Cover Certain Costs Incurred in Making Student Loans from Borrowed Funds:		
Section 744(b) - Health professions schools....	Indefinite	$2,284,000
Section 827(b) - Schools of Nursing.....	Indefinite	1,716,000

Payment of Sales Insufficiencies and Interest Losses

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation
1968	$ 250,000	$ 250,000	$ 250,000	$ 250,000
1969	200,000	200,000	200,000	200,000
1970	957,000	957,000	957,000	957,000
1971	3,083,000	3,083,000	3,083,000	3,083,000
1972	4,000,000	4,000,000	4,000,000	4,000,000
1973	4,000,000	4,000,000	4,000,000	4,000,000
1974	4,000,000	4,000,000	4,000,000	4,000,000
1975	4,000,000	4,000,000	4,000,000	4,000,000
1976	4,000,000			

Payment of Sales Insufficiencies and Interest Losses

	1975 Estimate		1976 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	---	---	---	---	---	---
Other expenses.....	---	$4,000,000	---	$4,000,000	---	---
Total.....	---	$4,000,000	---	$4,000,000	---	---

INTRODUCTION

This appropriation provides for those mandatory interest payments to the Treasury Department and the Government National Mortgage Association which arise form operation of the two student loan revolving funds, the Health Professions Education Fund and the Nurse Training Fund. As provided for by legislation, funds may be loaned to health professions schools and schools of nursing for use by the schools in making loans to students. Schools borrowing funds execute a note payable for the amount of the loan. Participation certificates (backed by these notes) may be sold to private investors by the Government National Mrotgage Association so that the funds may be replenished. Interest on appropriated funds loaned to the schools must be paid to the Treasury Department interest must be paid to the private investors, and payments must be made to schools for loan cancellations and forgiveness.

Fiscal Year 1975

The appropriation for 1975 for sales insufficiences and interest losses is $4,000,000. Included is $1,874,000 for payment of interest to the Treasury Department on $30,336,000 of appropriated funds loaned to schools during 1968 through 1971 to capitalize their student loan funds. Also included is $929,000 for interest due to holders of $14,569,000 of participation certificates issued by the Government National Mortgage Association. In addition, $1,197,000 is provided for payment to schools for cancellations of principal as provided for in section 744(b), Title VII and section 827(b), Title VIII of the Public Health Service Act, as amended.

Plans, Fiscal Year 1976

In 1976, payment of interest to the Treasury and to the Government National Mortgage Association will continue. In addition, students will continue to take advantage of the forgiveness benefits of the loan fund act.

Title VII, part C and Title VIII, part B of the Public Health Service Act, established a revolving fund from which health professions schools and schools of nursing could borrow in order to provide loans to their students. Public Law 89-751, the Allied Health Professions Personnel Training Act of 1966, amended the Public Health Service Act to authorize the Federal Government to pay the difference between the interest paid by students to the schools and the interest payable by the schools to the Government National Mortgage Association and the Treasury.

The 1976 request of $4,000,000 will provide the following Federal Payments:

$2,576,000 -- Payment of Interest Differential
($1,764,000)-- Health Professions Education Fund
($812,000)-- Nursing Training Fund

$164,000	--	Payment of Insufficiencies
($129,000)	--	Health Professions Education Fund
($35,000)	--	Nurse Training Fund

$1,260,000	--	Payment of Cancellation
($391,000)	--	Health Professions Education Fund
($869,000)	--	Nurse Training Fund

Interest Losses (Differential)

(1) This category provides for Federal payment to the United States Treasury representing the difference between the United States Treasury interest rate and that paid by the schools on an estimated $28,987,000 (Health Professions Education Fund, $18,597,000 and Nurse Training Fund, $10,390,000) loaned to schools.

$1,811,000	--	Payment of Interest Differential to Treasury
($1,162,000)	--	Health Professions Education Fund
($649,000)	--	Nurse Training Fund

(2) This category provides for Federal payment ot the Government Nation Mortgage Association representing the 5.25 percent interest rate on $14,569,000 ($11,459,000, Health Professions Education Fund, and $3,110,000, Nurse Training Fund) worth of paper (pledged notes) held by the Government National Mortage Association as collateral for participation certificates sold to private investors.

$765,000	--	Payment of Interest to Government National Mortgage Assn.
($602,000)	--	Health Professions Education Fund
($163,000)	--	Nurse Training Fund

Insufficiencies

This category provides for Federal payment to the Government National Mortgage Association representing the difference between the 5.25 percent interest rate earned by the student loan paper (promissory notes) and the 6.38 percent rate by the Government National Mortgage Association on $14,569,000 worth of paper (participation certificates) held by the public.

$164,000	--	Payment of Insufficiencies
($129,000)	--	Health Professions Education Fund
($35,000)	--	Nurse Training Fund

Cancellations

This category provides for Federal payment ot Health Professions schools and schools of Nursing for loan cancellations under section 744(b), Title VII and section 827(b), Title VIII of the Public Health Service Act. These loans are cancelled by either the death or permanent and total disability of the borrower or the borrower's willingness to serve in an area designated by the Secretary as being eligible for loan cancellations.

$1,260,000	--	Payment of Cancellations
($391,000)	--	Health Professions Education Fund
($869,000)	--	Nurse Training Fund

Payments of Sales Insufficiences and Interest Losses

EXPLANATION OF WHY THERE ARE NO
FUNDS IN THE INTERIM PERIOD

Undisbursed balances in the Health Profession Education Fund and the Nurse Training Fund are adequate to meet all obligations that are incurred during the interim period July 1, 1976 through September 30, 1976.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

	Page No.
FY 1976 Budget	
Appropriation Language	198
Amount available for obligation	199
Summary of changes	200
Explanation of changes	200
Obligations by activity	201
Obligations by object	201
Authorizing legislation	202
Table of estimates and appropriations	203
Justification:	
General statement	204
Program purpose and accomplishments	206
Interim Period Budget (July 1, 1976 through September 30, 1976)	
Amounts available for obligation	207
Obligations by activity	208
Obligations by object	208
Justification	209

Appropriation Estimate

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

To carry out section 1622 of the Public Health Service Act, $10,000,000 shall be available without fiscal year limitation for the payment of interest subsidies.

For the "Medical facilities guarantee and loan fund," for the period July 1, 1976, through September 30, 1976, $7,000,000 to remain available until expended.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

Amounts Available for Obligation

	1975	1976
Appropriation	---	$10,000,000
Receipts and reimbursements from: Non-Federal sources	$53,902,000	45,800,000
Unobligated balance, start of year	85,997,000	68,917,000
Unobligated balance, end of year	-68,917,000	-61,804,000
Total, obligations	70,982,000	62,913,000

Summary of Changes

1975 Estimated obligations	$70,982,000
1976 Estimated obligations	62,913,000
Net Change	-8,069,000

	1975 Base Pos.	1975 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Interest subsidies on direct and guaranteed loans	--	$8,532,000	--	$+11,038,000
Total, increases	--	---	--	+11,038,000
Decreases:				
B. Program:				
1. Direct loans	--	62,450,000	--	-19,107,000
Total, decreases	--	---	--	-19,107,000
Total, net change	--	---	--	-8,069,000

Explanation of Changes

Increases:

A. Built-in:

A built-in increase of $11,038,000 for interest subsidies is necessary to honor the interest subsidies for loans already committed and those to be entered into in FY 1975 under the remaining FY 1973 authorizations.

Decreases:

B. Program:

A decrease of $19,107,000 is due to normal decline in direct loans resulting from the expiration of the FY 1973 loan allocation, with no additional allocations being made.

Obligations by Activity

Page Ref.		1975 Estimate	1976 Estimate	Increase or Decrease
	Interest subsidies.....	$8,532,000	$19,570,000	$+11,038,000
	Direct loans.....	62,450,000	43,343,000	-19,107,000
	Total obligations.....	70,982,000	62,913,000	-8,069,000

Obligations by Object

Investments and loans.....	$62,450,000	$43,343,000	$-19,107,000
Grants, subsidies, and contributions.....	8,532,000	19,570,000	+11,038,000
Total obligations by object.....	70,982,000	62,913,000	-8,069,000

Authorizing Legislation

Legislation	1976 Authorized	1976 Appropriation Requested
Public Health Service Act:		
Section 1622--General provision relating to loan guarantees and loans.....	such sums as necessary	$10,000,000

Medical Facilities Guarantee and Loan Fund

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1971	$5,000,000	$5,000,000	$5,000,000	$5,000,000 a/
1972	20,300,000	100,300,000	100,300,000	100,300,000 b/
1973	2,500,000	2,500,000	2,500,000	2,500,000 a/
1974	---	---	---	---
1975	---	---	---	---
1976	10,000,000			

a/ Interest subsidy funds appropriated into the parent account and later transferred to the Medical Facilities Guarantee and Loan Fund.

b/ Of the $100,300,000 appropriated, $20,300,000 was for interest subsidies and $30,000,000 to establish revolving funds for direct loans. These funds were appropriated into the parent account and later transferred to the Medical Facilities Guarantee and Loan Fund. The remaining $50,000,000 reflects a supplemental appropriation for loan defaults.

Justification

Medical Facilities Guarantee and Loan Fund

	1975 Estimate Amount/Pos.	1976 Estimate Amount/Pos.	Increase or Decrease Amount/Pos.
Personnel compensation and benefits.....	---	---	---
Other expenses.....	$70,982,000	$62,913,000	$-8,069,000
Total.....	70,982,000	62,913,000	-8,069,000
(Total Budget Authority)....	(---)	(10,000,000)	(+10,000,000)

General Statement

A Medical Facilities Loan and Loan Guarantee Fund has existed since 1972 under the preceding Hill-Burton Medical Facilities Construction Program. The Fund is retained in the new health planning and resources development legislation under Title XVI of the PHS Act to provide construction monies to the States through loans or loan guarantees with interest subsidies.

Loan and Guarantee Fund

In recent years the availability of third party reimbursement for capital depreciation has constituted a viable substitute for the use of direct grant funds in many instances by enabling medical facilities to obtain construction loans in private markets. The Loan and Loan Guarantee Fund (referred to as "the fund") makes additional construction monies available to eligible facilities through (1) direct loans, (2) loan guarantees, and (3) interest subsidies on guaranteed loans. The fund is established in the Treasury, without fiscal year limitation, to discharge responsibilities under guarantees; for payment of interest on the guaranteed loans to nonprofit sponsors; for direct loans (these loans are sold and guaranteed); for payment of interest on direct loans which are sold and guaranteed; and for repurchase of direct loans which have been sold and guaranteed.

Under the new law, the allocation to each State of the loan principal for both guaranteed loans (with interest subsidies) and direct loans is based on a formula which considers such factors as the State's population, financial need, and the need for the types of medical facilities described above. (These monies are available for commitment by the State for three years.)

Applicants for direct loan funds may be a State, a political subdivision of a State, or any other public or private nonprofit entity. Loan guarantees may be made to non-Federal lenders or to the Federal Financing Bank for the payment of principal and interest on loans made to nonprofit private entities. The holders of such loans under the loan guarantee program may receive an amount sufficient to reduce the interest due on their loans by three percent per year, and in fact the holder of each loan guaranteed has a contractual right to receive such interest payments from the United States.

Loans and loan guarantees under the new program are to provide support for projects which will: (1) modernize medical facilities; (2) construct new outpatient medical facilities; (3) construct new inpatient medical facilities in areas which have experienced recent rapid population growth; and (4) convert existing medical facilities for the provision of new health services.

Under optimal conditions in which no loan or loan guarantee is defaulted, interest subsidies constitute the only expenditure of the Loan and Loan Guarantee Fund which must periodically be replenished. A proportion of the funds authorized for direct and guaranteed loans is set aside to cover any defaults if they should occur; direct loans are made from the remaining amount; these direct loans are in turn sold and guaranteed to the Federal Financing Bank and become "guaranteed loans." Thus a revolving fund is set up in which direct loans are made and sold so that the amount available for direct loans is fairly static, but the number and amount of guaranteed loans (and interest subsidies) increases every year. The limits to the amount which may be guaranteed or loaned in any year are established by Congress.

To date, a total of $27,800,000 has been appropriated for interest subsidies. Past year expenditures ($44,000 in 1972; $512,000 in 1973; $3,209,000 in 1974; and an estimated $8,532,000 in 1975) amount to $12,297,000. Since sufficient funds were available from previous year appropriations, no funds were required to cover interest subsidy expenditures in 1974 or 1975. However, the projected $19,600,000 obligation for 1976 (increasing the total expenditure to $31,899,000) will more than deplete available funds. Therefore, an additional appropriation of $10,000,000 is requested in 1976 to cover obligations for interest subsidies and to provide an approximate $5,000,000 balance at the end of 1976.

Since 1972, 258 projects in 233 communities have been assisted under the Loan and Loan Guarantee Fund through February 1975. Two hundred forty-seven projects involved modernization of existing facilities via replacement, alterations, or the provision of additional services such as outpatient or long-term care. Only 11 completely new hospitals (i.e., not replacement of old facilities) were aided. Loan guarantees over this period totaled $942,300,000 and direct loans amounted to $97,700,000.

HEALTH RESOURCES ADMINISTRATION

Health Planning and Resources Development

Program Purpose and Accomplishments

Activity: Medical Facilities Guarantee and Loan Fund (Public Health Service Act, Title XVI, Part C)

1975 Estimate			1976	
				Budget Estimate
Pos.	Amount	Authorization	Pos.	Amount
--	---	Indefinite	--	$10,000,000

Purpose: To provide construction monies to the States through loans and loan guarantees (with interest subsidies) for (1) modernization of medical facilities; (2) construction of new outpatient medical facilities; (3) construction of new inpatient medical facilities in areas which have experienced recent rapid population growth; and (4) conversion of existing medical facilities for the provision of new health services.

Explanation: The Medical Facilities Loan and Loan Guarantee Fund is established without fiscal year limitation to discharge responsibilities for: payment of interest on the guaranteed loans to nonprofit sponsors; direct loans (these loans are sold and guaranteed); payment of interest on direct loans which are sold and guaranteed; and repurchase of direct loans which have been sold and guaranteed.

Accomplishments in 1975: To date (i.e., February 1975) the Loan and Loan Guarantee Fund (under the previous Hill-Burton medical facilities construction program) has assisted 258 projects in 233 communities with a total of $1,040,000,000 ($942,300,000 for loan guarantees and $97,700,000 for direct loans).

$439,542,670 of uncommitted funds which had been allocated in the States in 1973 were still available for obligation in 1975. It is expected that the States would commit this entire amount before the end of the year.

Objectives in 1976: A significant amount of time in 1976 will be spent developing, publishing and obtaining approval for the rules and regulations for the new loan and loan guarantee program authorized under Public Health Service Act, Title XVI Part C.

In addition to this effort, loans and loan guarantees authorized under the old medical facilities program will be administered.

Total obligations of $62,913,000 for 1976 include $19,570,000 for interest subsidies and $43,343,000 for direct loans.

To date, $27,800,000 has been appropriated for interest subsidies. Past year (1972 through 1975) expenditures amount to $12,297,000 which in addition to the projected $19,600,000 obligation for 1976 more than depletes the available funds. An additional $10,000,000 appropriation will cover interest subsidy expenditures for 1976 and will provide an approximate $5,000,000 balance at the end of the year.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

Amounts Available for Obligation

	1976 Estimate	Interim Period Estimate
Appropriation	$10,000,000	$7,000,000
Receipts and reimbursements from:		
Non-Federal sources	45,800,000	---
Unobligated balance, start of year	68,917,000	61,804,000
Unobligated balance, end of year	-61,804,000	-61,804,000
Total, obligations	62,913,000	7,000,000

Obligations by Activity

Page Ref.		1976 Estimate Amount	Interim Period Estimate Amount
	Interest subsidies.....	$19,570,000	$7,000,000
	Direct loans.....	43,343,000	---
	Total obligations.....	62,913,000	7,000,000

Obligations by Object

	1976 Estimate	Interim Period Estimate
Total number of permanent positions..	--	--
Full-time equivalent of all other positions.....	--	--
Average number of all employees.....	--	--
Investments and loans.....	$43,343,000	---
Grants, subsidies, and contributions.....	19,570,000	$7,000,000
Total obligations by object.....	62,913,000	7,000,000

Justification

Medical Facilities Guarantee and Loan Fund

	1976 Estimate Amount	Interim Period Estimate Amount
Other expenses	$62,913,000	$7,000,000
(Total Budget Authority)	(10,000,000)	(7,000,000)

General Statement

A Medical Facilities Loan and Loan Guarantee Fund has existed since 1972 under the preceding Hill-Burton Medical Facilities Construction Program. The Fund is retained in the new health planning and resources development legislation under Title XVI of the PHS Act to provide construction monies to the States through loans or loan guarantees with interest subsidies.

Loan and Guarantee Fund

In recent years the availability of third party reimbursement for capital depreciation has constituted a viable substitute for the use of direct grant funds in many instances by enabling medical facilities to obtain construction loans in private markets. The Loan and Loan Guarantee Fund (referred to as "the fund") makes additional construction monies available to eligible facilities through (1) direct loans, (2) loan guarantees, and (3) interest subsidies on guaranteed loans. The fund itself is established in the Treasury, without fiscal year limitation, to discharge responsibilities under guarantees; for payments of interest on the guaranteed loans to nonprofit sponsors; for direct loans (these loans are sold and guaranteed); for payment of interest on direct loans which are sold and guaranteed; and for repurchase of direct loans which have been sold and guaranteed.

The loan principal for both guaranteed loans (with interest subsidies) and direct loans is allocated to the States according to a formula which considers such factors as the State's population, financial need, and the need for the types of medical facilities described above. These monies are available for commitment by the State for three years.

Loans and loan guarantees under the new program are to provide support for projects which will: (1) modernize medical facilities; (2) construct new outpatient medical facilities; (3) construct new inpatient medical facilities in areas which have experienced recent rapid population growth; and (4) convert existing medical facilities for the provision of new health services.

Under optimal conditions in which no loan or loan guarantee is defaulted, interest subsidies constitute the only expenditure of the Loan and Loan Guarantee Fund which must periodically be replenished. A proportion of the funds authorized for direct and guaranteed loans is set aside to cover any defaults if they should occur

(i.e., $50,000,000); direct loans are made from the remaining amount (i.e., $30,000,000); these direct loans are in turn sold and guaranteed to the Federal Finance Bank and become "guaranteed loans." Thus a revolving fund is set up in which direct loans are made and sold so that the amount available for direct loans is fairly static, but the number and amount of guaranteed loans (and interest subsidies) increases every year. The limits to the amount which may be guaranteed or loaned in any given year is established by the appropriation committee under the new legislation.

To date, a total of $37,800,000 has been appropriated for interest subsidies. Past year expenditures ($44,000 in 1972; $512,000 in 1973; $3,209,000 in 1974; $8,532,000 in 1975 (estimate); $19,600,000 in 1976 (estimate)); total at $31,900,000. This amount together with the projected $7,000,000 obligation for the three-month interim period will more than deplete available funds. Therefore, an additional appropriation of $7,000,000 is requested for the interim period to cover obligations for interest subsidies and to provide an approximate $5,000,000 balance at the end of this period.

WEDNESDAY, APRIL 23, 1975.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

WITNESSES

LEE SMITH, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, OFFICE OF ADMINISTRATIVE MANAGEMENT, PUBLIC HEALTH SERVICE

MORTON SMALL, CHIEF, FINANCIAL MANAGEMENT BRANCH, BUREAU OF MEDICAL SERVICES
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

Mr. FLOOD. Now we have retirement pay and medical benefits. That presentation will be made by Mr. Lee Smith, Director of the Office of Personnel Management, Office of Administrative Management, Public Health Service.

We have a biographical sketch of Mr. Smith which we will insert in the record at this point and we will also insert your statement.

[The biographical sketch and statement follow:]

BIOGRAPHICAL SKETCH

Name: Lee W. Smith.

Position: Assistant Surgeon General, 0-7; PHS Commissioned Corps; Director, Office of Personnel Management, Office of Administrative Management, Public Health Service.

Birthplace and date: Pittsburgh, Pa.; February 13, 1928.

Education: 1952 B.S., University of Pittsburgh; 1953 M.S., University of Pittsburgh; 1958 M.P.H., University of Pittsburgh; 1968 Management Course, American Management Association; Graduate Biochemistry, Genetics and Microbiology Courses, George Washington University School of Medicine.

Military: 1945–49 U.S. Navy, Ph. M. 2/C—Laboratory Technician.

Experience: 1973 to present—Director, Office of Personnel Management, OAM/PHS. 1971–73—Director, Commissioned Personnel Division, OPT/OS. 1968–71—Executive Assistant to the Deputy Assistant Secretary for Personnel and Training, OPT/OS. 1968—Director, Division of Operations and Services, OP/PHS. 1967–68—Special Assistant to the Deputy Surgeon General, PHS. 1965–67—Chief, Personnel Utilization Branch, OP/PHS. 1961–65—Placement Officer, Bureau of Medical Services and Deputy Chief, Personnel Utilization Branch, OP/PHS. 1959–61—Research Associate, National Institute of Allergy and Infectious Diseases, NIH. 1958–59—Research Fellow, National Institutes of Health, Department of Epidemiology and Microbiology. 1955–57—Laboratory Director, Encephalitis Investigations Unit, Center for Disease Control, PHS. 1953–55—Research Associate, Graduate School of Public Health, University of Pittsburgh.

Memberships: American Public Health Association, American Society of Microbiology, Phi Sigma Society, Sigma Xi, Delta Sigma Phi, Commissioned Officers Association—PHS, various Masonic bodies.

Awards: Phi Sigma and Sigma Xi, Exceptional Capability Promotion—1966, PHS Meritorious Service Medal—1969.

Mr. Chairman and members of the committee, I am pleased to appear before you today to discuss the 1976 budget request for retirement pay and medical benefits for commissioned officers. This appropriation authorizes such amounts as may be necessary for certain mandatory payments under two programs.

PAYMENTS TO RETIRED OFFICERS AND SURVIVORS

The first program covers payments to retired officers of the Public Health Service and to survivors of deceased retired officers. Benefits to retired officers

are authorized by section 211 of the Public Health Service Act, while those to survivors are authorized by the Retired Serviceman's Family Protection Plan and the Survivors Benefit Plan enacted in 1972. The request for $23 million for 1976, an increase of $2.9 million, is based on a projection of beneficiaries now being paid, with adjustments for anticipated additions and terminations. The number of retired officers, 1,307 as of June 30, 1974, is projected to increase to 1,406 by June 1975 and 1,505 by June 1976. The number of survivors' annuitants, 102 as of June 30, 1974, is expected to be 113 by June 1975 and 128 by June 1976.

DEPENDENT'S MEDICAL CARE

The Dependents' Medical Care Act and the Military Medical Benefits Amendments of 1966 authorize the provision of medical care to active duty and retired uniformed service personnel, their dependents, and dependents of deceased servicemen of the Coast Guard, the National Oceanic and Atmospheric Administration, and the Public Health Service. Expenses of the dependents' medical care program are for contract medical care furnished to dependents and retirees. The costs in Federal facilities are for inpatient care. Contract care costs in non-Federal facilities provide inpatient care, outpatient care, and rehabilitative care for physically handicapped and mentally retarded dependents.

The budget request is for approximately $22 million in 1976. This represents an increase of $2.9 million which will provide $2.1 million for non-Federal care due to cost increases and $0.8 million for care in Federal facilities due to increased workloads.

SUMMARY

In summary then, the total estimate for 1976 is $45 million which will provide $23 million for the retired officers and survivors program and $22 million for the dependents' medical care program.

OBLIGATION IN FISCAL YEAR 1975

Mr. FLOOD. Last year you asked for $43.4 million for 1975 for this activity. But your budget now shows you will only obligate $39,200,375. What accounts for that?

Mr. SMITH. In part it was based on our projections of the number of retirees and the number of survivors which were reduced, and additionally there was a considerable increase anticipated in our cost for medical care in the private sector which did not reach the projections that were made.

Mr. FLOOD. You are asking for $45 million in 1976?

Mr. SMITH. Yes, sir.

Mr. FLOOD. That is $6 million over your 1975 obligation level.

Mr. SMITH. Yes, sir.

Mr. FLOOD. That is $6 million over your 1975 obligation level. In light of the fact that the 1975 obligations themselves will be 10 percent lower than the amount appropriated, what in the world makes you believe you are going to need 15 percent more in 1976 under those circumstances?

Mr. SMITH. We have not completed, of course, the total 1975 budget expenditure.

Mr. SMALL. We have taken a fresh look at the 1976, Mr. Chairman, and we believe the $45 million to be our most accurate estimate we can come up with at this time.

Mr. FLOOD. Your 1975 obligations now are going to be lower than the amount we appropriated?

Mr. SMALL. That is right.

Mr. FLOOD. That being so, how do you justify 15 percent more in 1976?

Mr. SMITH. There are considerably increased costs as well as increase in the number of persons who will receive retired pay as survivors as well as increased workloads for the medical care program.

Mr. FLOOD. Do you have any statistics to establish that or are you just guessing? What do you mean a number, 2 or 200? That is quite a difference in dollars.

Mr. SMITH. Our projected increases in the number of retired would be a total increase of 99 persons who would receive retired pay. In addition to that, with the increases of cost of living to which they are entitled as well as those retiring at this point in time on higher pay scales, the total dollar cost of that program has increased significantly.

PROPOSED TRANSFER OF TWO PHS HOSPITALS TO COMMUNITIES

Mr. FLOOD. When the President submitted his 1976 budget to the Congress he said that two Public Health Service hospitals will be transferred to the local community. What impact would that have on payments to retired officers?

Mr. SMITH. If that should be approved and that action undertaken, then there would be increased cost in the private sector medical care budget estimates.

Mr. FLOOD. The closing of two such hospitals would increase the cost of providing medical care to retirees and to dependents. Is that right?

Mr. SMITH. That is right.

Mr. SMALL. We have not projected any such increase in this budget.

Mr. FLOOD. But that would follow?

Mr. SMALL. Yes, sir.

Mr. FLOOD. Is this uncertainty over whether or not these hospitals are going to remain open going to cause any increase in retirement do you think?

Mr. SMITH. It is possible. It certainly has in earlier years and it can be projected to do so. The uncertainties of program direction have had some adverse effect on increasing our numbers in retirement.

Mr. MILLER. Yesterday we got that question in the Senate, Mr. Chairman. I think the head of the hospitals testified, as Mr. Smith has, that uncertainty is pretty much a thing of the past. The 1974 budget said we were going to close all eight hospitals and that really created uncertainty and caused people to retire.

Mr. FLOOD. That has been going on many years.

Mr. MILLER. In the context in which it is presented in the 1976 budget, which is, if the planning agencies approve and if the Congress approves closing two hospitals, we are going to look into that possibility. I don't think that possibility is shaking the structure very much.

BONUS PAY AND MEDICAL CARE COST

Mr. FLOOD. Does this new bonus pay you have for the commissioned officers have any effect upon the retirement?

Mr. SMITH. It is not having any significant effect on the senior officer retirement. The previous authorized continuation pay was paid to senior officers in approximately the same amount they are receiving.

Mr. FLOOD. You are requesting an additional $2.9 million in medical care costs. Do you attribute this to the cost of care which you obtain from what we call non-Federal facilities?

Mr. SMALL. Correct.

Mr. FLOOD. What percentage of medical care for dependents is obtained from non-Federal facilities?

Mr. SMALL. In total for 1976, the total costs for medical care in the program is $22 million and of that amount nearly $18 million is for non-Federal care.

Mr. SMITH. That is in-patient as well as out-patient care, including the handicapped program and drugs.

Mr. FLOOD. Thank you very much, gentlemen.

Justification of the Budget Estimates

Appropriation Estimate

RETIREMENT PAY AND MEDICAL BENEFITS FOR

COMMISSIONED OFFICERS

For retired pay of commissioned officers, as authorized by law, and for payments under the Retired Serviceman's Family Protection Plan Plan; Survivor Benefit Plan and payments for medical care of dependents and retired personnel under the Dependents' Medical Care Act (10 U.S.C., ch. 55), such amount as may be required during the current fiscal year.

For "Retirement Pay and Medical Benefits for Commissioned Officers," such amount as may be required during the period of July 1, 1976, through September 30, 1976. (Department of Health, Education, and Welfare Appropriation Act, 1975.) 1/

Explanation of Language Changes

1/ Language has been added to permit implementation of the Congressional Budget and Impoundment Act of 1974 which changes the beginning of the fiscal year from July 1, to October 1.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health

Retirement Pay and Medical Benefits
for Commissioned Officers

Amounts Available for Obligation

	1975	1976
Appropriation (Indefinite).....	$43,422,000 1/	$45,013,000

1/ Current estimates reflect a need of $39,200,000.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health

Retirement Pay and Medical Benefits
for Commissioned Officers

Obligations by Activfty

Page Ref.		1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
242	Retirement payments.....	$19,645,000	$22,481,000	+$2,836,000
243	Survivors' benefits.....	431,000	512,000	+81,000
244	Dependents' medical care..	19,124,000	22,020,000	+2,896,000
	Total Obligations....	$39,200,000	$45,013,000	+$5,813,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health

Retirement Pay and Medical Benefits
for Commissioned Officers

Obligations by Object

	1975 Estimate Amount	1976 Estimate Amount	Increase or Decrease Amount
Benefits for former personnel	$20,076,000	$22,993,000	+$2,917,000
Other services	19,124,000	22,020,000	+2,896,000
Total obligations by object	$39,200,000	$45,013,000	+$5,813,000

Summary of Changes

1975 estimated obligations	$39,200,000
1976 estimated obligations	45,013,000
Net change	+$5,813,000

	Base Amount	Change from Base Amount
Increases:		
A. Built-in:		
1. Estimated costs for projections of retirements during 1975 to full year and for estimated additional retirements during 1976	$19,645,000	+$2,836,000
2. Estimated increase in survivors' benefits	431,000	+81,000
3. Estimated cost for increased inpatient and outpatient care for retirees and dependents	17,778,000	+2,748,000
4. Estimated increase for ancillary services (drugs, handicapped care, contractors' fees, etc.) required by an expanding beneficiary population	1,346,000	+148,000
Total, Increase	---	+$5,813,000
Total, Net change	---	+$5,813,000

Explanation of Changes

Increases:

A. Built-in:

1. The estimated increase of $2,836,000 will provide the full year payments of officers retired during 1975, and for the net increase of 99 officers estimated to retire during 1976, and for the projected cost-of-living increase during 1976.

2. The estimated increase of $81,000 will provide for a net increase of 15 survivors receiving benefits.

3. An estimated increase of $2,748,000 will provide for a 14% increase for inpatient care and a 25% increase for outpatient care. An estimated increase of $1,989,000 is due to increased medical care costs in the private sector. An estimated increase of $759,000 will provide for a higher workload.

4. An estimated $148,000 will provide for higher drug usage costs and contractors' fees. These increases are related to the rise in the number of beneficiaries eligible for care: 104,700 in 1975 to 107,300 in 1976.

Retirement Pay and Medical Benefits
for Commissioned Officers

Table of Estimates and Appropriations

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1966	$7,850,000	$7,850,000	$7,850,000	$7,833,800
1967	8,977,000	8,977,000	8,977,000	10,837,719
1968	13,391,000	13,391,000	13,391,000	11,290,000
1969	15,090,000	15,090,000	15,090,000	14,265,000
1970	16,700,000	16,700,000	16,700,000	16,567,000
1971	19,501,000	19,501,000	19,501,000	21,349,000
1972	23,196,000	23,196,000	23,196,000	23,960,000
1973	29,163,000	29,163,000	29,163,000	28,106,000
1974	34,103,000	34,103,000	34,103,000	34,524,000
1975	43,422,000	43,422,000	43,422,000	43,422,000
1976	45,013,000			

Justification

Retirement Pay and Medical Benefits
for Commissioned Officers

	1975 Amount	1976 Amount	Increase or Decrease Amount
Other expenses	$39,200,000	$45,013,000	+$5,813,000

General Statement

This appropriation provides for retirement payments to Public Health Service officers who have been, or will be retired, for age, disability, or length of service as well as for payments to the survivors of deceased, retired officers who had received reduced retirement payments under the provisions of the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

Provision is also made for the cost of medical care provided in non-Public Health Service facilities to dependents of Public Health Service beneficiary members of the uniformed services and retired personnel in accordance with the Dependents' Medical Care Act as amended by Public Law 89-614.

Retirement Payments

	1975 Amount	1976 Amount	Increase or Decrease Amount
Other expenses	$19,645,000	$22,481,000	+$2,836,000

This activity provides for mandatory payments for officers who have been retired for age, disability, or specified period of service in accordance with provisions of law.

It is estimated that during 1976, 87 officers will retire for years of service, 12 for age, and 20 for disability, for a total of 119 retirements. An estimated 20 officers will be dropped from the roll, resulting in 1,505 officers on the retirement roll as of June 30, 1976, an increase of 99 over the estimated 1,406 officers on the roll on June 30, 1975.

Survivors' Benefits

	1975 Amount	1976 Amount	Increase or Decrease Amount
Other expenses.....	$431,000	$512,000	+$81,000

This estimate provides for the payment of annuities to the survivors of retired officers who elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan, Survivor Benefit Plan.

The estimate is based upon payments to the following numbers of annuitants:

June 30, 1972	73
June 30, 1973	81
June 30, 1974	102
June 30, 1975 (est.)	113
June 30, 1976 (est.)	128

Dependents' Medical Care

	1975 Amount	1976 Amount	Increase or Decrease Amount
Other expenses.....	$19,124,000	$22,020,000	+$2,896,000

The Dependents' Medical Care Act (10 U.S.C., Ch. 55), as amended by P.L. 89-614, provides for an expanded and uniform program of medical care for active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. This activity covers the cost of inpatient and outpatient care (including care of handicapped dependents of active duty personnel) outside the Public Health Service, both in non-Federal and in uniformed service facilities, to dependents of eligible personnel of the United States Coast Guard, the National Oceanic and Atmospheric Administration, and the Public Health Service; and to retired personnel of these services.

A net increase of $2,896,000 is requested in 1976. In the non-Federal care area $2,884,000 is needed to cover the anticipated increase in rates and workloads for inpatient and outpatient care as well as for handicapped care, drugs and contractors' services. In the Federal care area, we anticipate an increase of $12,000 due to an increase in workload.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits
for Commissioned Officers

Program Purpose and Accomplishments

Activity: Retirement pay (Public Health Service Act as amended, Sec. 211; 10 U.S.C., 1201)

1975 Amount	1976 Authorization	1976 Budget Estimate Amount
$19,645,000	Indefinite	$22,481,000

Purpose: This authority provides for payments to commissioned officers of the Public Health Service who have been retired for age, disability, or specified period of service.

Explanation: Public Health Service officers do not contribute to the retirement fund. The fund is supported by the Federal Government through an annual appropriation.

Accomplishments in 1975: An estimated net increase of 99 officers will be added to the retirement roll, resulting in a total of 1,406 retirees as of June 30, 1975.

Objective for 1976: A net increase of 99 officers will result in an estimated total of 1,505 retired officers at the end of Fiscal Year 1976.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits
for Commissioned Officers

Program Purpose and Accomplishments

Activity: Survivors' benefits (10 U.S.C., ch. 73)

1975 Amount	1976 Authorization	1976 Budget Estimate Amount
$431,000	Indefinite	$512,000

Purpose: Under the provisions of the Retired Serviceman's Family Protection Plan, Survivor Benefit Plan, retired personnel who elect to receive reduced amounts of retired pay are able to provide for monthly payments to be continued to their survivors.

Explanation: This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Accomplishments in 1975: It is estimated that there will be a total of 113 annuitants as of June 30, 1975.

Objectives for 1976: It is estimated that there will be a total of 128 annuitants as of June 30, 1976.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits
for Commissioned Officers

Program Purpose and Accomplishments

Activity: Dependents' medical care (10 U.S.C., ch. 55)

1975 Amount	1976 Authorization	1976 Budget Estimate Amount
$19,124,000	Indefinite	$22,020,000

Purpose: The Dependents' Medical Care Act, as amended by P.L. 89-614, provides for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members.

Explanation: This activity is used to satisfy the mandatory obligations of the Public Health Service. They arise because a dependent or a retiredperson receives care in an approved medical facility. The amount of the expense varies, depending on the medical facility that the Public Health Service beneficiary enters: (1) if care is given in a Public Health Service facility, there is no charge under the Dependents' Medical Care Act (these costs are chargeable to the appropriation, Health Services); (2) if care is given in a facility of another uniformed service, the Public Health Service is billed directly by that organization; and (3) if medical care is given in a private facility, a contractor, such as Blue Cross, pays the hospital and bills the executive agent in the Department of Defense, who in turn bills the Public Health Service for the services rendered.

Accomplishments in 1975: A daily average of 336 persons will be hospitalized, 27,400 total outpatient claims will be processed, and 175 handicapped dependents will receive care.

Objectives for 1976: This program is designed to provide care to an estimated 107,300 eligible beneficiaries, an increase of 2,600 over 1975. The level of funding requested will allow delivery of health care to this larger beneficiary population. Currently, we are anticipating in non-Public Health Service facilities an average daily inpatient load of 345, total outpatient claims of 31,600 and 175 handicapped care cases.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health

Retirement Pay and Medical Benefits
for Commissioned Officers

Amounts Available for Obligation

	1976	July 1-Sept. 30
Appropriation (Indefinite).....	$45,013,000	$13,552,000

Obligations by Activity

	1976 Estimate Amount	July 1-Sept. 30 1976 Estimate Amount
Retirement payments.....	$22,481,000	$7,019,000 A/
Survivors' benefits.....	512,000	149,000 B/
Dependents' medical care.....	22,020,000	6,384,000 C/
Total obligations.....	$45,013,000	$13,552,000

A/ Estimated fourth quarter of 1976 ($5,771,700) plus $1,247,300 for 49 officers expected to retire during the period and the annualization of F.Y. 1976 retirements.

B/ One quarter of F.Y. 1976 amount ($128,000) plus $21,0000 for an estimated five additional annuitants and the annualization of F.Y. 1976 annuitants.

C/ One quarter of F.Y. 1976 estimate($5,505,000) plus $879,000 for an estimated 3% increase in workload and an 11% increase in costs.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health

Retirement Pay and Medical Benefits
for Commissioned Officers

Obligations by Object

	1976 Estimate Amount	July 1-Sept. 30 1976 Estimate Amount
Benefits for former personnel.....	$22,993,000	$7,168,000
Other services.....	22,020,000	6,384,000
Total obligations.....	$45,013,000	$13,552,000

51-805 O - 75 -- 57

SPECIAL REPORTS

Mr. FLOOD. The Department of Health, Education, and Welfare has furnished this committee with several special reports which I will insert into the record at this time:

[The information follows:]

BLACK LUNG DISEASE (COAL WORKERS' PNEUMOCONIOSIS)

Obligations
(in thousands)

	1972	1973	1974	1975 Estimate	1976 Estimate
Public Health Service:					
Center for Disease Control National Institute for Occupational Safety and Health.....	$6,138	$3,317	$8,483	$4,300	$4,400
National Institutes of Health National Heart and Lung Institute.....	120	163	200	250	325
Total.....	6,258	3,480	8,683	4,550	4,725

Black lung disease, or coal workers' pneumoconiosis, is an incapacitating, life-shortening constellation of disease processes initiated by the inhalation and retention in the lungs of coal and other mine dusts.

Black lung disease kills more Americans than all other forms of pneumoconiosis (the various dust-inhalation diseases) combined, and afflicts approximately 100,000 living Americans. While it is largely preventable by the use of known methods of minimizing exposure to dust, the disease is irreversible once established.

Thus, complete control of black lung disease in this country requires extensive application of known preventive measures, and basic and clinical research to learn where and how we may intervene to slow or halt the progression of the underlying disease processes.

CENTER FOR DISEASE CONTROL

National Institute for Occupational Safety and Health

Activity Under the Federal Coal Mine Health and Safety Act of 1969 (P.I. 91-173)

Under provisions of the Federal Coal Mine Health and Safety Act of 1969 (P.L. 91-173), as amended, the National Institute for Occupational Safety and Health is the Department's primary program dealing directly with health of coal miners. The National Institute provides a research and technical service to raise the health status of workers through prevention and control of occupational diseases.

In 1972 the National Institute for Occupational Safety and Health (NIOSH) completed the first round of medical examinations of underground coal workers under provisions of Title II of the Federal Coal Mine Health and Safety Act of 1969. This first effort covered 72,504 coal workers who availed themselves of the opportunity for these examinations. In addition, approximately 1,000 coal workers at surface coal mines were examined to identify any unusual health problems from this type of employment. In late 1973, the second round of medical examinations called for by the Act was initiated and about 6,000 miners participated. By the completion of this round in 1975 it is hoped that 90,000 of the approximately 110,000 underground coal miners will avail themselves of the medical examination opportunity.

During 1974 NIOSH initiated a program, through grants and contracts, for the provision of diagnostic and treatment services for active and inactive miners suffering from respiratory disease. This funding will support approximately 25-30 clinics which should become self-sufficient through the third party pay mechanism. In late 1975, the continued second round of medical examinations of the 90,000 underground coal miners will be completed.

In 1975 and 1976 the NIOSH proposes to develop mandatory health standards, preventive examination programs, and protective engineering techniques to assure that coal workers are provided a working environment which will prevent occupationally caused diseases, by:

(a) Providing for an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung Benefits;

(b) Developing and conducting research to develop techniques for the prevention and control of occupational diseases of coal miners and persons who work with or around the products of coal mines, in areas outside of such mines.

3

NATIONAL INSTITUTES OF HEALTH
National Heart and Lung Institute

The National Heart and Lung Institute bears primary responsibility for basic and clinical research concerned with the respiratory (pulmonary) system and with developing improved methods for the prevention, diagnosis, and relief of chronic lung diseases (other than the infectious and malignant lung diseases, which are the provinces of the National Institute of Allergy and Infectious Diseases and the National Cancer Institute, respectively).

In partial fulfillment of this mission, the NHLI Division of Lung Diseases spent $400,000 in FY 1974 in support of four regular research grants and five subprojects within Specialized Center of Research (SCOR) pulmonary programs for research on certain of the pneumoconioses. This is a collective term for a number of different diseases caused by the inhalation and retention in the lungs of mineral or vegetable dusts and including such diseases as silicosis, asbestosis, byssinosis, and--the subject of this report--coal workers' pneumoconiosis, or black lung disease. Approximately half of this sum was spent for research directly on black lung disease.

Magnitude of the Problem

Black lung disease is believed to account for more deaths--approximately 1,000 per year in this country--than all other forms of pneumoconiosis combined, and afflicts an estimated 90,000 to 125,000 miners. According to a 1967 report by the Pennsylvania Department of Public Health, 43,000 Pennsylvania coal miners had X-ray evidence of coal workers' pneumoconiosis and more than half of these (nearly 24,000 miners) were disabled by it. A recent nationwide survey by the Public Health Service and the Bureau of Mines indicates that nearly 30 percent of working coal miners in the U.S. have black lung disease.

Typically, victims of black lung disease require a decade or more of exposure to mine dusts before they are incapacitated or killed by the disease. In the interim, they experience progressively severe wheezing, coughing, and shortness of breath, and increased susceptibility to colds and other respiratory infections, including tuberculosis.

Black Lung: A Composite of Several Disorders

The progressive, irreversible nature of the disease is revealed by autopsy examination of lung tissues following varying periods of exposure to the mine dusts.

This also shows that the disease actually involves five or more different disease processes:

- Some of the inhaled dusts are retained and become permanently incorporated into the walls of the small air passages (bronchioles) and sacs (alveoli) to form microscopic, focal deposits called macules. In aggregate, these macules are grossly visible as blackened patches and streaks in lung slices even following only a few years of dust exposure.

- Destruction of lung tissue around the dust deposits produces a halo of emphysema--in effect, a dead air space--around each macule.

- In some patients, scar tissue formation (fibrosis) occurs between macules, and can involve large areas of the lung. While the occurrence and severity of fibrosis are unpredictable, fibrosis has been associated in some studies with exposure to silica dust, and in others with tuberculosis.

. The eventual development of chronic bronchitis and the more generalized forms of emphysema contribute importantly to shortness of breath and disability in coal workers' pneumoconiosis.

. Finally, many afflicated workers exhibit as a complication of their disease elevated blood pressure in the lungs (pulmonary hypertension) and, as a consequence of this increased pressure, compensatory enlargement of the right side of the heart.

Heart failure is the most common cause of death in persons with black lung disease; many others succumb to respiratory failure during an acute respiratory infection.

Treatment

There is no form of treatment that will halt, much less reverse, the slow course of black lung disease. Available therapy is aimed either at complications of the disease, or at relieving some of its symptoms. Antibiotics are used to treat respiratory infections, and cardiotonic drugs enable the heart to pump more blood through remaining lung tissue. Also available are a number of drugs to ease breathing by dilating air passages or by dissolving obstructive mucus secretions. Research continues on other ways of ameliorating the symptoms and complications of black lung disease.

Prevention

Prevention is the only known way of controlling black lung disease and, as studies in Great Britain have demonstrated, is quite effective. This is accomplished by reducing dust levels in working environments, and limiting the duration of exposure to dust. Specific measures include the use of dust monitoring systems, wetting practices, air filters, dust masks and other equipment to collect or suppress dust at its source or remove it from the atmosphere, improved ventilation systems, rearranging work shifts to reduce individual exposure to particularly dusty environments, periodic X-ray examinations and pulmonary function tests to detect the disease in its early stages, and other screening tests to identify job-applicants and others who are especially susceptible to the disease. People with an hereditary deficiency of the enzyme alpha-1-antitrypsin are more likely to develop black lung disease in a particulary severe form in terms of both earlier onset and relatively more rapid progression of the disease. And, for reasons as yet unknown, workers who have either tuberculosis or rheumatoid arthritis together with black lung are especially prone to develop massive pulmonary fibrosis.

Finally, anti-smoking campaigns and above-ground air pollution control activities are (or should be) important elements of any effort to control black lung disease. These additional airborn insults to the lungs aggravate the symptoms and accelerate the course of the disease.

In Great Britain, where coal workers' pneumoconiosis was first described and control measures initiated 30 years ago, mortality and disability from black lung has been halved. Complete control of the disease in this country, including help for those who already have black lung, requires extensive application of known preventive measures and the acquisition of new information concerning the underlying disease processes.

Need for Research

We need to know more about the relationships between these processes, whether they occur simultaneously or sequentially, and correlate them in turn with other internal and environmental factors operant in the disease's several phases. Only in this way can we hope to find a weak link in the chain of events that all too often culminates in disability and death--a link that we can break with appropriate therapy to arrest the disease process.

Current Research Efforts

The research approach outlined above is being pursued in NHLI grant-supported studies of black lung disease. One study, conducted by Dr. Richard L. Naeye at the Pennsylvania State University, is a combined clinical-epidemiological-pathological investigation of the five or more disease processes that constitute coal workers' pneumoconiosis. This comprehensive project includes autopsy studies of 500 coal workers, 300 miners' wives, 650 people not associated with the coal mining industry and 400 rural Pennsylvanians matched for age and race with other groups. Though not completed, this study has yielded interesting preliminary findings correlating types and severities of disease manifestations with exposure to silica dust at different mine sites and in soft and hard coals.

Dr. Naeye's research team has also developed a very sensitive test system for investigating the role of immunological defense mechanisms in black lung disease. There is some clinical and autopsy evidence that sensitization and subsequent exposure to any one of a number of antigenic substances (bacteria, fungi, organic and inorganic dusts, etc.) may figure prominently in some cases of black lung, even perhaps in the early stages of the disease. The test, a more sensitive modification of the lymphocyte transformation test, reveals immunological responses of cultured white blood cells to even very low levels of antigens, such as might be found in the respirable dusts of mine air samples.

The investigators have just begun to apply the test, obtaining blood samples from coal miners in various mining regions, isolating and culturing the lymphocytes and challenging these cells with respirable dust samples (supplied by the Bureau of Mines) and with specific antigens including beryllium, purified protein derivative (PPD) of tubercle bacillus culture, and certain fungal antigens known to be present in some mines. In time, the studies will include additional organic compounds as these are isolated and identified from mine dusts by Bureau of Mines chemists in Pittsburgh.

Similar research questions are being pursued by Dr. Russell A. Harley, Medical University of South Carolina, Charleston. His studies in animals are testing the hypothesis that progressive massive fibrosis of the lungs (PMF), one of the most dramatic possible consequences of black lung disease, is the result of an altered inflammatory response of lung tissue caused by an induced hypersensitivity. This hypersensitivity is thought to be accentuated by absorption of antigen to the stored dust in the lungs, which prevents the destruction of the antigen and favors prolongation of its activity.

Dr. Harley and co-workers found that guinea pigs sensitized with histoplasmin or with tubercle bacillus antigens developed a persistent chronic inflammatory reaction involving the alveolar wall in response to subsequent exposure to the appropriate antigen alone. But when pre-sensitized animals were given massive doses of coal dust along with the antigen, massive lesions containing trapped dust and fibrosis (connective tissue, or scarring characteristic of early PMF) were produced. The PMF guinea pig lung has many of the gross and microscopic features of the human disease in its early stages, including the diffuse distribution of fine coal dust and the uniformly black pigmentation of the lung.

The studies are incomplete, but the finding that massive amounts of dust are required for the development of PMF in experimental animals suggests that even moderate reductions in exposure to mine dust may effectively prevent the development of this dread complication of black lung disease in humans.

IMMUNIZATION

Obligations for Immunization

	1972	1973	1974	1975 estimate	1976 estimate
Center for Disease Control:					
Grants	$17,000,000	$10,050,000	$10,650,000 1/	$5,900,000	$4,960,000
Direct operations	1,042,000	1,040,000	1,228,000	1,339,000	1,384,000
Total	18,042,000	11,090,000	11,878,000 1/	7,239,000 2/	6,344,000

The Center for Disease Control coordinates a nation-wide effort to control vaccine preventable diseases. The Center, in conjunction with Public Health Service Regional Offices, provides technical assistance to State and local health departments in the development and implementation of programs, and provides project grant assistance to supplement State and local immunization programs. Historically these grants have been used to develop and implement programs designed to reduce the backlog of susceptibles to a given disease soon after a vaccine for the disease was developed. Project grants for polio immunization programs were followed by project grants for measles immunization, and in 1969, by project grants for rubella immunization programs. In 1971 these grants were expanded to include support for immunization programs against measles, polio, diphtheria, pertussis, and tetanus as well as rubella. This action was taken when reported measles cases increased from 22,231 in 1968 to 75,290 in 1971 and when immunity levels against polio continued to decrease. Late in 1974, support for the limited purchase of the combined measles-mumps-rubella vaccine was authorized.

These expanded efforts resulted in substantial increases in the distribution of vaccines. Since 1969, more than 48 million doses of rubella vaccine have been administered, with over 37 million being administered in public grant-supported programs. Annual distribution of measles vaccine has increased from 4.0 million in 1971 to 7.5 million in 1973 and 1974.

The increases in vaccine distribution were followed by sharp decreases in reported cases of disease. Reported cases of measles decreased from 75,290 in 1971 to 22,085 in 1974; the number of cases of rubella decreased from 56,552 in 1970 to 11,836 in 1974; and only 5 cases of polio were reported in 1974. This represents the lowest number of cases ever reported for each of these diseases.

1/ Includes $4,450,000 of 1973 funds restored in 1974.

2/ 1975 Rescission Budget.

LEAD-BASED PAINT POISONING

Obligations

(In thousands of dollars)

	1972	1973	1974	1975 Estimate	1976 Estimate
Public Health Service:					
Center for Disease Control.....	$7,546	$7,805	$14,250 2/	$7,385	$4,401
Health Services Administration..	1/	1/	1/	1/	1/
Office of Human Development.....	1/	1/	1/	1/	1/
Total.....	7,546	7,805	14,250	7,385	4,401

The potential for lead poisoning in children exists wherever lead-based paint is accessible in deteriorating housing. There are an estimated 2.5 million children in the United States between the ages of one and six years in such housing which contain lead-based paint surfaces.

Of the children subjected to excessive lead absorption, many will suffer the serious sequela of lead poisoning, such as mental retardation or death. Control of childhood lead poisoning is based on identification and medical management of lead intoxicated children and the abatement of the lead-based paint hazard in their home environment.

1/ Obligations not identifiable.
2/ Includes $4,500 of 1973 funds restored in 1974.

CENTER FOR DISEASE CONTROL

The Center for Disease Control administers the Childhood Lead-Based Paint Prevention Program at a national level. Project grants are provided to communities to stimulate lead-based paint poisoning detection, treatment and hazard abatement. During FY 1974, 41 project grant communities tested 371,955 children for evidence of undue lead absorption of whom 16,228 had elevated blood lead levels and 3,801 required chellation treatment.

Late in FY 1974, the number of grant assisted communities increased to 77, and one-time grants were awarded to 28 State laboratories to develop or expand lead analysis laboratory capabilities.

In addition, the Center provides technical services and consultation to local and State programs in the area of program development and implementation, program evaluation, and laboratory proficiency.

HEALTH SERVICES ADMINISTRATION
BUREAU OF COMMUNITY HEALTH SERVICES
Activities Related to Childhood Lead-Based Poisoning

The Bureau of Community Health Services is responsible for administering programs and projects funded under Title V of the Social Security Act to promote the health of mothers and children. In the area of childhood lead-based paint poisoning, its activities may be summarized as follows:

Public Education

MCHS in BCHS pioneered public education and Federal activities related to childhood lead poisoning when it was still a part of the Children's Bureau. In 1967, it published Lead Poisoning in Children, which became instrumental in generating public as well as governmental awareness of the problem. Shortly after its publication, the booklet was reprinted and distributed by the Lead Industries Association. So far, 113,000 copies have been reprinted by the Lead Industries Association. In addition, BCHS/MCH has distributed free over 20,000 copies of the publication to State and local health departments, Crippled Children's agencies, Children and Youth Projects, Mental Retardation Services, schools of public health, libraries, Department of Health, Education, and Welfare regional offices and other governmental and private agencies. Thousands of these booklets have been sold separately by the Government Printing Office. This booklet is expected to be revised in the near future.

This initial publication was followed by a number of other public education materials which produced further impact on the problem: "Childhood Lead Poisoning - An Eradicable Disease" (Children, January - February 1970, reprinted by MCHS); "Selected Bibliography on Lead Poisoning in Children" (DHEW Publication No. 72-5105, 1971); "Watch Out for Lead-Paint Poisoning" (DHEW Publication No. 72-5101, 1972) and its Spanish version "¡Cuidado La Pintura de Plomo Envenena!" (DHEW Publication No. 72-5106, 1972). These leaflets were written for the population at risk. Since their publication, approximately 463,000 copies of the English version and 110,000 of the Spanish version have been distributed by BCHS.

In addition, since early 1974 the Department of Housing and Urban Development has distributed about 200,000 copies of the leaflet to officials in housing authority, occupants of older houses, and others.

"Undue Absorption of Lead Among Children - A New Look At An Old Problem" was published in the New England Journal of Medicine in March, 1972 and reprinted by MCH for distribution. This paper stresses the concept of prevention of lead poisoning through early identification of children with evidence of undue lead absorption before they become poisoned and permanently damaged.

The article has been particularly well received by the scientific community as attested by the large number of requests for reprints. "Preventing Lead Poisoning in Children" appeared in the Jan.-Feb. "Children Today." This paper summarizes some recent information about this disease such as its occurrence outside of the inner cities, and the many sources of hazardous lead exposure other than lead-based paint. It was reprinted by BCHS for distribution. Another paper entitled "Vulnerability of Children to Lead Exposure and Toxicity" was published in two parts, in the Medical Progress Section of the New England Journal of Medicine (Dec. 6 and Dec. 13, 1973). Requests for reprints of this paper have been very heavy and include several from foreign countries.

Children and Youth Projects

The C&Y projects provide comprehensive health care for children of preschool and school age in low-income areas, and cover on a continuous basis, the whole range of medical, dental, and emotional health needs of the children. Many projects include screening for lead poisoning as part of their health maintenance program, but the comprehensive nature of these projects makes it impossible to determine the exact amount of money spent on lead poisoning prevention and control.

In FY 74, 62 Children and Youth Projects were funded through the BCHS totalling about $48,000,000. As of June, 1974, there were 529,418 registrants in these projects. Among new registrants, 55.8% were black, 38.3% were white, and 5.9% classified as "Other".

Of 49 projects that responded to a 1973 survey on the problem of lead poisoning, 51% stated that lead poisoning was a public health problem and 49% stated that it was not. Among the 49 projects, 2 routinely tested all children seen by the project, 12 routinely tested all children under 6 years of age, 20 tested only children considered high risk for lead poisoning, and 15 reported no testing. 18 projects reported that a total of 922 children were treated for lead poisoning for the 12-month period ending September 30, 1972.

Research Grants

Under its research grants, BCHS supported a study of micro tests for childhood lead poisoning at the Johns Hopkins University if FY '71 amounting to $56,718. The investigation was extended and completed in February 1972.

Some results of the study which was also supported by other grants were presented by its investigator Dr. J. J. Chisolm at the Third Meeting of the Subcommittee on the Toxicology of Metals under the Permanent Commission and International Association of Occupational Health in Tokyo in November, 1974. The paper, entitled "Interrelationships Among Blood Lead Concentration, Quantitative Daily ALA-U and Urinary Lead Output Following Calcium EDTA" will be published in the Proceedings of the meeting. Other data from the study are being prepared for separate publication.

Consultation

The pediatric consultant in BCHS, Dr. Jane S. Lin-Fu, devotes much of her time to the problem of lead poisoning. Over the years, she has provided consultation to various DHEW as well as other federal, state and local agencies, Congressional committees, voluntary agencies and a variety of other groups.

She contributed to the section on childhood lead poisoning in the Prevention Handbook published recently by the NARC, and to A Guide to Screening for EPSDT under Medicaid prepared by the DHEW in cooperation with the American Academy of Pediatrics. Earlier she helped develop the President's Committee on Mental Retardation Position Statement on Lead Poisoning in Children, and served as consultant and contributor to the National Academy of Science in the preparation of its exhaustive study entitled "Airborne Lead in Perspective."

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary, HEW, to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

In localities where lead paint is a hazard, children in Head Start and other OCD demonstration programs, such as Home Start and Parent and Child Centers, are screened for lead poisoning. Children who test positively are then referred for continued medical treatment. In arranging for detection and medical care, the Office of Child Development's early childhood programs are making use of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program (Title XIX).

The Office of Child Development's lead paint poisoning activities are primarily focused on creating public awareness of the lead paint problem. Films and pamphlets are used to inform parents of the hazard of peeling paint and to instruct them in prevention and control measures.

PEDIATRIC PULMONARY CENTERS

Obligations
(in thousands)

	1972	1973	1974	1975 Estimate	1976 Estimate
Public Health Service:					
Health Services Administration.....	$756	0	$1,498	$2,000	0

Health Services Administration

One of every six children in the United States under 17 years of age has one or more chronic pulmonary diseases. Of all the chronic diseases which affect children in this age range, pulmonary diseases account for 70 percent.

Three major chronic pulmonary diseases are asthma, chronic bronchitis and cystic fibrosis. The fact is that each of these diseases is usually manageable when detected in the very young child.

Chronic pulmonary disease is a life-long problem. Its management requires sophisticated equipment and personnel. In the course of these diseases acute episodes, requiring hospitalization, occur. Treatment, while not intensive once a stabilized status is achieved, is time-consuming and continuous medical supervision, over extended periods of time, is required. The availability of appropriate manpower, therefore, is crucial to ameliorating the problem.

If primary pulmonary diseases are treated promptly and comprehensively, secondary chronic problems in the total (adult) population may be prevented or ameliorated. As it now stands, 36 million adults have chronic pulmonary disease, and the mortality rate is now more than 35,000 deaths annually. It has been doubling every five years. During 1968, respiratory cripples in the United States were paid $90 million in Social Security payments--7 percent of all disability payments--second only to sums paid for heart disease patients.

In 1970, the 4.6 million children with asthma and chronic bronchitis lost 9.9 million school days and had 20.0 million days of non-hospital disability. In 1971, children with asthma and chronic bronchitis spent 21.0 million days in short term hospitalizations.

Children with asthma comprise 19 percent of those children in the birth to 17 age group with chronic pulmonary disease. Failure to recognize and treat it can lead to serious lung damage. While it is rarely fatal it can, if untreated, cause permanent pathological changes in the airways and lungs and make the child vulnerable to other illnesses. With proper management, 90 percent of asthmatic children will obtain complete relief (attacks ended) or marked reduction in severity of attacks.

Children with chronic bronchitis comprise 24 percent of those children in the birth to 17 age group with chronic pulmonary disease. If it is not brought under control, chronic bronchitis can lead to pulmonary emphysema. If treated adequately and early, its effect on the condition of pulmonary tissues can be minimized.

Improved treatment procedures are having some effect on the average in-patient hospital stay for asthma and chronic bronchitis patients. Between 1968 and 1971, the average patient day for asthma decreased from 6.6 to 4.5 and for chronic bronchitis from 5.1 to 4.5.

How many children have cystic fibrosis cannot be readily established. This hereditary disease, first described in 1938, is estimated to occur in one of every 2000 white live births. The gene frequency in the white population may be as high as one in 40. An increasing number of cases of cystic fibrosis is now being recognized in Blacks, Puerto Ricans and Orientals. Progress in diagnosis and treatment has removed the certainty of early death for children with cystic fibrosis. A number have now reached adulthood, completed their college education, have married and are living productive lives. A favorable outcome depends on early detection and treatment. 1/

There are ten centers currently receiving BCHS support: University of Colorado, Philadelphia Regional Pediatric Pulmonary Center, Columbia University, University of Washington, Tulane University/Louisiana State University, University of Hawaii, University of California (Irvine), Presbyterian Hospital (Albuquerque), University of Puerto Rico, and Georgetown University. They have in common their concern with training personnel for serving children with pulmonary disease and the organization and delivery of such services. Within this context, however, program emphasis varies widely depending upon factors such as geography, climate, existing resources and needs. For example, the nature of the Hawaii and Puerto Rico programs is related to their geographic isolation and their basically limited resources. The disease categories with which they are primarily concerned are different from mainland programs in that they are less concerned with cystic fibrosis (lower incidence due to genetic composition of the population and a lesser management problem because of climatic factors) but more heavily concerned with chronic asthma because of the abundance of tropical fungi and other allergens.

The New York and Philadelphia programs both serve large populations concentrated in relatively limited geographic areas with a multiplicity of agencies, facilities and services. Thus, they are more concerned with coordination of services and training to avoid duplication and to make the most appropriate use of the particular capabilities of each resource.

The Colorado and New Mexico programs both serve relatively sparse population scattered over vast geographic areas, including all or portions of adjacent States. These programs have a particular emphasis on patient referrals and transport, and on training personnel to upgrade services in areas remote from the major medical centers.

These sorts of differing emphases within a common framework of interests and concerns could be described for each of the presently funded centers. The above examples serve to illustrate the nature of the problem and the diversity of approaches being used for its resolution.

Although there is variation among the centers in services offered each typically takes personal and family histories, makes complete physical examinations with emphasis on the thorax, takes other measurements, and performs laboratory tests.

In-patient care is available for complex diagnostic problems or acute exacerbation of the disease which cannot be managed at home.

1/For further detail, see Cystic Fibrosis, NIH

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Out-patient services provide regular checkup and planned follow-up of patients and their treatment regimens. All centers have out-patient clinics, most of them on a weekly basis. Five have satellite clinics where services are taken to a peripheral area that does not have a pulmonary clinic. The satellite clinics can screen, offer ambulatory treatment and followup examination but lack the sophisticated laboratory equipment and personnel for certain evaluation and procedures.

Referrals of patients come from private physicians, public health clinics and nurses, their own or other hospitals or facilities, or from the families themselves.

Casefinding involves screening for signs or history suggestive of pulmonary disease. Those thus identified require a full evaluation before a diagnosis can be made.

Physical therapy provides an exercise routine to improve the vital capacity and promote bronchial drainage. Such therapy also includes graduate programs to keep the total muscle tone of the body at acceptable levels without producing undue fatigue. Eight centers offer physical therapy.

Inhalation or respiratory therapy is an outgrowth of physical therapy. The availability of these diversified services is relatively new. This form of therapy, which includes oxygen and regulated moisture regimes, has enabled many chidlren to survive more comfortably. All centers have these services.

Social work and psychological services provide the support that parents must have. They also complement and make possible the vigorous therapeutic program these children need in order to survive and to have as healthy growth and development as possible. Seven centers provide psychosocial services, using either a social worker or a psychologist or both.

All centers have some patient and family education counseling and two have genetic counseling.

Two offer dietary and nutrition services to selected children but all attempt to make the family aware that an adequate well balanced diet is essential for these children, who must have basic foods in order to approximate normal growth and development. The nurse frequently gives nutritional advice.

All centers provide pediatric pulmonary disease consultation to health professionals and health facilities within the area they serve.

Facilities. Nine centers are consortia of hospitals, clinics and specialty laboratories. Four are affiliated with more than one educational institution. All have intensive care units for infants and/or children.

Staff. All the centers have a physician as medical director, usually a specialist in pediatric pulmonary diseases who demonstrates a basic concern for all aspects of preventive child care. Most have an assistant to the director who either is a physician specialist or a physician fellow who is learning the specialty. Two have administrative

coordinators to amalgamate use of center facilities in total program efforts. In six centers, allied programs in the consortia have their own staffs, which generally consist of a physician director, an assistant who may be a physician or fellow, nurse or social worker, a pulmonary technician and a clerk.

All centers have at least one registered nurse who has had on-the-job training in pulmonary care. This individual frequently plays the principal role in organizing the program and is required to offer services where other disciplines are not represented. The centers also have one or more pulmonary technicians as well as clerical personnel.

Most centers rely on other hospital staff to provide such patient services as nursing, physical and inhalation therapy, social service, dietary/nutrition evaluation and laboratory tests.

The centers, depending on size, affiliations and resources, can also call on part-time assistance from the faculty in such specialties as cardiology, virology, genetics, microbiology, immunology, phychiatry, physiology and anesthesiology. Some centers obtain these special services from outside sources.

Training. Since nine of the ten centers are consortia which provide a considerable range of services to a large number of patients, they present a particularly favorable climate for training.

The number of trainees is restricted to insure that supervision is adequate. Training objectives are two-fold. One is to train physicians and others to specialize in chronic pulmonary diseases. A second is to acquaint a larger number of health professionals with information about pulmonary disorders in children, so that they have a high index of suspicion, will be able to provide improved primary care for these children at home, and will make prompt referral of complex cases to other resources for care.

The ten Pediatric Pulmonary Centers were originally Cystic Fibrosis Centers until receipt of Federal funds. At that time they broadened their scope to include other pulmonary diseases. The first Federal funds were received in 1968, initially administered through the Chronic Disease Program of the Department of Health, Education, and Welfare, and subsequently transferred to the Regional Medical Programs Service. Administration of the program was placed in the Bureau of Community Health Services in 1973.

Funding has been erratic over the years. Fiscal year's 1974 and 1975 obligated funds at about the rate of $2,000,000 per year.

In addition to providing direct services at the 10 centers, a major goal for these funds is to provide training to the maximum numbers possible of physicians, nurses, and allied health personnel to provide adequate services to infants and children with chronic pulmonary disease. Long-term training has been provided to physician/fellows in most of the Centers. Short-term programs such as seminars, workshops, and in-services education have been offered for practicing physicans, nurses, respiratory therapists, nutritionists and other professional workers in all ten centers.

THE SUDDEN INFANT DEATH SYNDROME

In the United States, the sudden infant death syndrome (SIDS), also known as crib death, is the leading cause of death among infants between the first and twelfth months of life. It is estimated that each year approximately 7,500 to 10,000 infants, about two to three infants per 1,000 live births, succumb to this syndrome. Most victims are between the ages of one and six months. The incidence is highest between the second and fourth months of life.

The National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health has primary Federal responsibility for research on the sudden infant death syndrome. Other Federal programs related to SIDS involve the National Institute of Neurological Diseases and Stroke (NINDS) of the National Institutes of Health; the Bureau of Community Health Services, Office for Maternal and Child Health, Health Services Administration; the National Center for Health Statistics, Health Resources Administration; and the National Institute of Mental Health (NIMH), Alcohol, Drug Abuse, and Mental Health Administration.

Obligations for programs in Sudden Infant Death Syndrome

	1972	1973	1974	1975 estimated	1976 estimated
National Institutes of Health:					
National Institute of Child Health and Human Development	$3,550,000	$4,106,000	$5,300,000*	$4,700,000	$4,700,000
National Institute of Neurological Diseases and Stroke	---	105,000	---	---	---
Health Services Administration:					
Bureau of Community Health Services Maternal and Child Health	35,000	9,800	114,000	---	---
Health Resources Administration:					
National Center for Health Statistics	---	11,000	1,000	2,000	3,000
Alcohol, Drug Abuse and Mental Health Administration:					
National Institute of Mental Health	---	---	---	81,757	84,602
Total	$3,585,000	$4,231,800	$5,415,000*	$4,783,757	$4,787,602

*Includes restoration of 1973 impounded funds in the amount of $616,000.

NATIONAL INSTITUTES OF HEALTH

National Institute of Child Health and Human Development

The sudden infant death syndrome strikes without warning. In the majority of cases the baby is apparently in good health and feeds without difficulty. While there may be evidence of a slight cold or stuffy nose, there is no serious upper respiratory infection present. The infant is placed in his crib for a nap or for the night and several hours later is found dead. Following autopsy, no cause of death can be identified. In a large proportion of the victims, however, minute hemorrhages have been found within the chest; the babies are otherwise free of abnormal tissue changes.

Crib death is a world-wide health problem. It occurs more frequently in males than in females. The incidence is higher in non-white than in white babies, in families of lower socioeconomic status, in premature infants, particularly those who had gestational ages between 34 and 35 weeks, and in babies who had recent infections. Twins may be especially vulnerable to SIDS. It is likely that this tendency is related to their typical lower birth weight or shortened gestational period. Most crib deaths in the United States occur in the cold weather months between November and March. The risk appears to be highest in crowded environments.

Why these babies die is unknown. Many reasons have been offered to explain the deaths, including neurophysiologic, immunologic, cardiorespiratory, endocrine, and infectious disease causes. There does not appear to be any single explanation. All factors believed to be associated with the syndrome appear to be intertwined. It is not known, however, which one of the associations is most important.

The Sudden Infant Death Syndrome Act of 1974

On April 22, 1974, President Nixon signed into law The Sudden Infant Death Act of 1974 (P.L. 93-270). The Act fixes by statute the responsibility of NICHD for the conduct of SIDS research; requires the Secretary to develop public information and professional educational materials; authorizes grants and contracts for projects to collect and analyze information as to the causes of SIDS and to provide information and counseling to families affected by SIDS; and requires specific reports to Congress pertaining to progress of programs concerned with SIDS.

The National Institute of Child Health and Human Development has been designated as the lead agency for P.L. 93-270 and has been given responsibility for coordination and development of an implementation plan of the law. The implementation plan was submitted to the Assistant Secretary for Health on September 1, 1974. It has also been incorporated into the DHEW Child Health Task Force Operational Plan for FY 1975. In addition, the National Institutes of Health selected SIDS for FY 75 tracking through the NIH Operational Planning System.

The DHEW has established an interdepartment committee to coordinate Federal efforts in SIDS. It is chaired by an office of the NICHD and has representation from the National Institute of Neurological Diseases and Stroke; the National Institute of Mental Health; Office for Maternal and Child Health, Bureau of Community Health Services; the National Center for Health Statistics, and the Office of Program Implementation, Office of the Assistant Secretary for Health. Representation from other related and interested Federal programs will be included as appropriate.

A meeting to discuss approaches to implementation of the SIDS Act was held at the National Institutes of Health on August 5, 1974, under the auspices of the Interagency Panel.[3] Its specific purpose was to obtain input from the scientific community, SIDS parent organizations, and other concerned citizens. Those attending included (a) officers and other members of parent organizations, (b) physicians, including forensic pathologists (medical examiners), psychiatrists (psychological counsellors), and pediatricians, (c) biostatisticians and (d) communications specialists.

Research Objectives in SIDS

During 1974 the NICHD continued to expand its research efforts on the sudden infant death syndrome. The objectives were:

1. To increase understanding of underlying mechanisms of the syndrome.

2. To identify infants at risk of becoming victims and to explore preventive approaches.

3. To elucidate the impact of a sudden and unexpected infant death on the subsequent behavior of parents and siblings.

4. To learn more about the management of SIDS cases in the United States and to develop guidelines for coroners, medical examiners, and pathologists in handling these cases.

5. To inform the scientific and general communities about SIDS through workshops, conferences, and publications.

NICHD Workshop and Lecture Series

Since 1971, the NICHD has been sponsoring a series of research planning workshops on this problem, to identify specific research areas in need of in-depth study. These workshops bring together expert investigators and attract a number of scientists to work on the problem of SIDS. A summary report of each Workshop has been published or is currently in press.

In February 1974, the NICHD initiated a lecture series on New Research Perspectives in the Sudden Infant Death Syndrome. The purpose of these lectures is to highlight recent research findings and share them with the scientific community and public. Four presentations were made in 1974. The subjects of the lectures were: New Approaches in Evaluating Infants at Risk; Hypoventilation: A Possible Cause for SIDS; Sleep Disorders and SIDS; and Infectious Disease Aspects of SIDS.

NICHD Research Program

The NICHD has developed its SIDS research around seven emphasis areas:

1. Abnormal sleep patterns related to breathing, circulation and other functions essential to life.

2. Respiratory, cardiac, and circulatory responses to such stimuli as excess carbon dioxide in the blood or oxygen deficiency.

3. The body's system for metabolic and temperature regulation and its response to environmental conditions.

4. The baby's developing immune system and how defects in development may predispose an infant to the syndrome.

5. The distribution of the sudden infant death syndrome within the population and characteristics surrounding its occurrence in order to identify infants at high risk.

6. Studies of the structural and functional changes in tissues and organs.

7. The psychological stresses experienced by the family and the community when a sudden and unexplained infant death occurs.

In FY 1974 there were 109 ongoing research projects pertaining to SIDS. They included 27 grants and contracts for research specifically concerned with SIDS, and 82 others for grants and contracts for related studies. FY 1974 support approximated $5.3 million compared with $4.1 million in FY 1973. Funding for FY 1975 will approximate $4.7 million.

There have been several important new findings about SIDS during the last fiscal year. It has been shown in infants that periodic cessation of breathing (apnea) during sleep and associated changes in heart rate are part of a developmental pattern that occurs during the early months of life. It has also been observed that the frequency and duration of apneic episodes in infants during sleep is influenced by the same factors that have been shown to characterize the infant at high risk for SIDS--low birth weight, shortened gestation, mild upper respiratory infection. Studies in kittens have revealed that they have periods of apnea during sleep, and when they are deprived of sleep, frequency of apneic episodes in a subsequent sleep period is markedly increased. Continuous periodic cessation of breathing, such as that which occurs during sleep apnea, can affect availability of oxygen to tissues. One of our grantees has shown that in some infants who have died from SIDS, the thickness of the muscle mass surrounding the small pulmonary arteries indicates that there has been a deficiency in the amount of oxygen entering the air spaces of the lung. This observation is indicative of a persistent chronic lack of oxygen to the area; this oxygen lack may be the result of prolonged periods of apnea during sleep.

NICHD Information Program

The Institute has several publications available for distribution to the scientific community and general public. Publications in print include:

Summary of Proceedings: Second International Conference on Sudden Infant Death Syndrome, Seattle, 1969

Facts About The Sudden Infant Death Syndrome.

SIDS: Selected Annotated Bibliography, 1960-1971

National Library of Medicine Literature Search on Reaction to Infant Death by Family and Social and Legal Institutions

Research Planning Workshop on The Sudden Infant Death Syndrome

SIDS Research Planning Workshop: Behavioral Considerations

SIDS Research Planning Workshop: Developmental Aspects of Infection and Immunology

5

SIDS Research Planning Workshop: Cardiorespiratory Phenomena

SIDS Research Planning Workshop: Neurophysiological Factors

SIDS Research Planning Workshop: Epidemiology

SIDS Research Planning Workshop: Pathology

Publications which should be available for distribution in FY 1975 include:

SIDS: Information for Parents and Rescue Workers

SIDS: Management of Cases in the United States

SIDS: Hope For Tomorrow's Children

SIDS Research Planning Workshop: Identifying Infants at Risk

SIDS Research Planning Workshop: Development of the Upper Airway

SIDS Research Planning Workshop: Post Mortem Evaluation for Investigative Efforts

SIDS Research Planning Workshop: Approaches to Establishing Case Registers and Clinical Trials

SIDS: Selected Annotated Bibliography, 1972-1974

The Sudden Infant Death Syndrome Act of 1974: Approaches to Implementation

The Role of Cardio-Respiratory Electronic Monitoring of Young Infants in the Home Environment

NATIONAL INSTITUTES OF HEALTH

The National Institute of Neurological Diseases and Stroke

The National Institute of Neurological Diseases and Stroke (NINDS) has contracted with the Pennsylvania State University to analyze the sudden infant death syndrome (SIDS) cases that occurred in the Collaborative Perinatal Project (CPP). All deaths among the 50,000 children of the CPP have been verified and classified; 115 SIDS cases have been identified. A set of matched controls from the CPP population has been selected. A multivariate analysis of 30 pregnancy and neonatal variables is under way in an effort to identify characteristics associated with SIDS occurrence. One of the important features of the CPP data as it pertains to SIDS cases, is that the information was collected prospectively, that is, these data were collected prior to the death. Biases inherent in retrospectively-collected data were thus avoided.

HEALTH SERVICES ADMINISTRATION

Bureau of Community Health Services, Office for Maternal and Child Health

Sudden infant death syndrome (SIDS) activities in the Bureau of Community Health Services, Office for Maternal and Child Health, were intensified considerably in 1974. The emphasis has been to develop the implementation plan for the service, professional education, and public information portions of the Sudden Infant Death Syndrome Act of 1974. Preparation of regulations required for the solicitation of grant application and contract proposals is in progress.

In September 1974, an ad hoc advisory committee was convened to consider the issues related to the service portions of the legislation. The members of this committee represented medicine, nursing, social work, medical examiners and coroners, and all are actively engaged in the delivery of counseling and other follow-up services to families who have experienced a loss of an infant to SIDS. This conference focused on the characteristic components necessary for service programs responsive to the needs of families as well as to the legislative mandate. The recommendations of this group will be incorporated into the SIDS program guidelines where appropriate.

A contract was awarded to script and produce a 20-minute, 16 mm color, sound training film for health professionals on Sudden Infant Death Syndrome. The purpose of the film is to increase the awareness of health professional audiences about the trauma and suffering experienced by families who have lost an infant to SIDS. It also will serve to motivate the health professionals to provide counseling to the families affected by SIDS. It is anticipated that the film will be completed by February 1975.

A teaching guide is being prepared to accompany the film. It will provide the discussion leader with some workable suggestions for helping parents. In addition it will include factual knowledge about the syndrome itself.

A one-year study designed to determine causes of death in all infants aged 28 days to 1 year in New York City and to make decisions with regard to the degree of preventability of death is currently funded by Maternal and Child Health. The sudden infant death syndrome is one category of deaths which is being investigated. Numerous cooperative arrangements with health care and social welfare agencies have been made in order to accurately determine the causes of death and the possible effects on postneonatal mortality of families' social and physical environments as well as their relationships to health care systems. This study will be completed early in 1975.

In several large cities and in some States, studies have been made in developing coordinated community service programs. Oregon is a notable example of a statewide approach to the problems of SIDS. The key to this voluntary program is an effective referral system coordinated at the State level between the medical examiner and the public health department. Either voluntarily or as States pass legislation related to the sudden infant death syndrome, similar statewide plans are evolving, as for example in California. Numerous cities and counties also are initiating voluntary service programs responsive to the family concerns.

Generally, through Maternal and Child Health activities of the local or State health departments, information about the sudden infant death syndrome and counseling is becoming more available to families. Services have been initiated with limited local resources in cities such as Seattle, New York, Los Angeles, Chicago and Philadelphia.

During this past year SIDS and its related concerns have received increased visibility through presentation of informational and educational programs resulting from MCH activities at national meetings, such as APHA; Maternal and Child Health national and regional staff conferences; local health department inservice programs, such as in Cleveland, Ohio; and at State nursing association meetings, for example, in Alabama.

7

HEALTH RESOURCES ADMINISTRATION

National Center for Health Statistics

During FY 74 a new coding scheme for sudden death was developed. It went into effect in calendar year 1973. Work was also begun on an article nosology; guidelines explained this new coding change to coders, pointing out to registrars that the term "sudden death" was an acceptable one, and they should discontinue querying it.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

In June 1974, the National Institute of Mental Health (NIMH) entered into a contract with the National Foundation for Sudden Infant Death, Inc., to develop and maintain a two-year program designed to provide educational and counseling information and service to medical professionals, paraprofessionals and families which have cases of sudden infant death.

Specifically, the contractor will identify and visit health departments in major American communities throughout the nation in order to consult with health officers and public health nursing directors on the humanizing of medical treatment for SIDS cases. Through the use of existing medical knowledge and expertise, publications, and health resources, the contractor will provide recommendations for procedures and guidelines in establishing a program to handle SIDS cases in a more compassionate and sensitive manner. Health consultants, staffs of community mental health centers, and representatives of parents organizations will be identified and their involvement encouraged in the communities visited.

The Division of Special Mental Health Programs, NIMH, conducted a special, two-day invitational work conference on the mental health/behavioral aspects of SIDS on November 20-21, 1974. The purpose of this meeting was for NIMH staff to explore with consulting experts, program content and strategies in connection with NIMH's responsibilities in implementing the Sudden Infant Death Syndrome Act of 1974. Eight consultants representing various mental health and behavioral science disciplines as well as medicine, nursing, and the clergy developed guidelines for specific research, training, and demonstration activities concerned with the mental health/behavioral aspects of SIDS.

VENEREAL DISEASES

Obligations
(in thousands)

	1972	1973	1974	1975 Estimate	1976 Estimate
Public Health Service:					
Center for Disease Control...	$28,230	$31,340	$32,313	$30,695	$28,364
National Institutes of Health National Institute of Allergy and Infectious Diseases.....	458	1,085	2,937	2,720	3,020
Total.....	28,688	32,425	35,250	33,415	31,384

During the past two decades, increases in the incidence of syphilis and gonorrhea have resulted in these two diseases re-emerging as significant health threats in our society. The Federal government is responding by assisting States through grant programs and technical assistance to mount more effective control programs while at the same time intensifying its basic and applied research programs in this field. The major Federal foci for the first activity are the Center for Disease Control (CDC) and the DHEW Regional Offices, while those for the second are the National Institute of Allergy and Infectious Diseases (NIAID) and the Center for Disease Control.

Yet the increases in syphilis and gonorrhea are not isolated phenomena, but have been accompanied by increases in a variety of other "sexually transmitted diseases" as well--diseases such as genital herpes, nonspecific urethritis, and trichomoniasis. Therefore, in addition to the major investments in syphilis and gonorrhea, NIAID and CDC sponsored research is also being directed toward these other diseases. The major objective is to characterize their pathophysiology and epidemiology sufficiently to permit recommendations to be made with respect to future control efforts.

These CDC and NIAID programs are more fully described in the following sections.

CENTER FOR DISEASE CONTROL

Venereal disease control efforts, a responsibility shared by all levels of government since the 1930's have had a profound impact on syphilis prevalence: Total reported cases of syphilis have decreased by almost one-half million since FY 1943, from 575,593 (the highest reported prevalence) to 84,164 cases in FY 1974. These control efforts have also resulted in reductions exceeding 85% in the late sequelae of syphilis: congenital syphilis down 99%; adult deaths from syphilis down 87% and first admissions to mental hospitals because of syphilitic psychosis down 98%.

From FY 1943 through FY 1973, the incidence of infectious syphilis has not declined steadily but has fluctuated: Cases declined after FY 1943, then rose to a peak of 106,589 in FY 1947. During the next 10 years, the incidence declined 94%, to a low of 6,251 cases. Beginning in FY 1958, infectious syphilis began to increase and by FY 1962, the increase had reached more than 200%. With the intensification of control efforts, cases began to decline in 1966 and declined by almost 1,000 cases annually until 1970. For the next 4 years, there were increases but the 24,728 cases reported in FY 1974 represented a decrease of 1.4% over the previous year. For the first half of FY 1975, reported cases of infectious syphilis have increased by 5.2% over FY 1974. This increase, however, appears to be focal and increased control program emphasis is being placed on these areas.

The per capita rates of primary and secondary syphilis among major cities ranged from a low of 2.3 cases per 100,000 population in Pittsburgh, Pennsylvania, to a high of 116.9 cases per 100,000 population in San Francisco, California. Among states, the rates ranged from a low of 0.7 in Montana to a high of 26.4 in Florida.

During FY 1974, late and late latent syphilis cases declined by 18.2%, reaching their lowest point since such statistics have been collected; congenital syphilis among individuals who acquired the disease some years ago declined by 19.2%; congenital syphilis in infants under 1 year of age declined by 13.8%; and total syphilis cases declined by 7.1% as compared with FY 1973.

Like syphilis, the number of reported cases of gonorrhea has fluctuated somewhat in the years since the 1940's, increasing rapidly to a peak of 400,639 in FY 1947 and then decreasing for 10 years after the introduction and wide use of penicillin. Reported cases of gonorrhea reached a low of 216,476 cases in FY 1957 and then began to rise again. The 874,161 cases reported during 1974 represent an increase of 8.0 percent over 1973. Although the long-term trend of gonorrhea incidence remains upward, this rate of increase was lower than that experienced during 1973 (12.7%) and 1972 (15.1%).

For the first 6 months of FY 1975, estimates on the basis of provisional data indicate that reported cases of gonorrhea increased by only 4.8%; cases among men by 3.2% and among women by 7.2%.

Trends have differed for males and females. During FY 1974, cases in males increased only 3.7% over cases reported in FY 1973, but in females, the increase was 15.0%. Although these changes in reported cases in part reflect increased casefinding and changes in reporting practices, they are also believed to reflect real changes in disease incidence, which appears to be leveling off. The trend of male morbidity should decline as screening and epidemiologic programs curtail the transmission of disease. Gonorrhea continues to be reported most frequently from large urban areas. Three cities re rted gonorrhea case rates of over 2,000 per 100,000 population (San Francisco, California, 2081.6; Washington, D. C., 2853.1; and Atlanta, Georgia, 3272.5).

Age-specific rates for infectious syphilis and gonorrhea show the young adults (20-24 years of age) to be at the greatest risk of acquiring disease. Among gonorrhea patients, teenagers(15-19 years of age) are the second highest risk group, although for syphilis victims it is the 25-29 year age group.

With infectious syphilis still occurring at a relatively high level and gonorrhea at the highest level ever reported in the United States, major emphasis continues to be placed upon developing and implementing control programs for venereal disease. Particular emphasis is focused on disease intervention activities designed to reduce the incidence of these diseases. The primary goals of these programs are (1) screening, by bacteriologic culture, high-risk female populations for gonorrhea; (2) surveillance over the serologic screening of specific population segments for syphilis; (3) application of the contact referral process to patients with infectious syphilis or gonorrhea; (4) education efforts directed toward communicating pertinent venereal disease facts to people at risk, with the objectives of preventing exposure or reexposure to infection, and of influencing infected individuals to seek early diagnosis and treatment; and (5) the active involvement of the private medical community in all aspects of venereal disease control.

In the FY 1974 screening programs for gonorrhea, 8,016,879 culture specimens were obtained from females, of which 345,090 (4.3%) were positive for gonorrhea. Positivity rates were highest (19.0%) among venereal disease clinic patients; however, only 10% of all test specimens were obtained in such clinics. Some 90% were obtained in other settings, and in these positivity rates ranged from a low of 1.4% among female dependents of military personnel to a high of 6.0% among enrollees of manpower training programs. Private physicians obtained test specimens from 2,286,743 females of which 44,540 (1.9%) were positive for gonorrhea. Provisional data for the first 6 months of FY 1975 indicate that 4,331,552 specimens (about 720,000 per month) from females were obtained from participating facilities of which 4.4% were positive for gonorrhea. In addition to screening efforts, gonorrhea control activities include applying the contact-referral process to volunteer male patients. During FY 1974, some 164,119 contacts to males infected with gonorrhea were examined as a result of the interview-contact referral procedure, and 142,554 persons were treated therapeutically or preventively. This process complements screening activities by extending outreach medical coverage for at-risk females.

Case detection and surveillance activities of the syphilis control effort tested an estimated 38 million persons for syphilis during FY 1974. Of these 1,100,000 had reactive test results, and over 68,000 were determined to be infected with syphilis. Application of the epidemiologic process to infectious syphilis cases resulted in the medical examination of 49,898 persons, of whom 6,940 (14%) were brought to treatment with previously undetected syphilitic infection.

Studies have shown that when preventive treatment is not given to persons exposed to syphilis within 30 days, 30% will develop syphilis. The percentage of primary and secondary syphilis contacts examined and given preventive treatment within 30 days of exposure to disease (high-risk group) increased from 92.6% in FY 1973 to 94.7% in FY 1974. The interview-contact referral-preventive treatment effort alone resulted in the prevention of an estimated 3,000 cases of syphilis in FY 1974.

Because the population is extremely mobile and a high rate of interstate and international transmission of venereal disease occurs, and because control efforts often require cooperative follow-up by two or more states and/or foreign countries, control program efforts are directed at ensuring a rapid exchange of vital epidemiologic data among states, local health departments and international jurisdictions. During FY 1974, more than 12,800 (11.3% of all contact reports) primary, secondary, and early latent syphilis contacts were reported as interstate or international contacts and 8.6% of those examined were infected with syphilis. To ensure the examination of the more than 760 contacts to infectious venereal disease named annually who reside outside the United States, all State and local health departments rely upon the CDC to process, translate, forward and feed back the results of exchanges with more than 60 international jurisdictions.

The importance of sexually transmitted diseases (STD) other than the five traditional "venereal" diseases (syphilis, gonorrhea, lymphogranuloma venereum, granuloma inguinale, and chancroid) is growing nationally. Major among these STD's are genital herpes, nonspecific urethritis, and trichomoniasis.

Genital herpes, a viral disease causing acutely painful genital lesions, is estimated to kill or mentally retard about one-half of the newborns who are thought to be infected at birth and is increasingly suspect as a major cause of cervical carcinoma. A second disease, Nonspecific urethritis, is caused, at least in part, by chlamydia and resembles gonorrhea in its most common clinical manifestations. It may be as prevalent or more prevalent than gonorrhea. A third disease, Trichomoniasis, is probably more common than gonorrhea and is probably responsible for some perinatal morbidity in addition to causing acute symptoms in both men and women. Although no cure is available for genital herpes, reasonably efficacious and inexpensive therapies are available for nonspecific urethritis and trichomoniasis.

To meet this challenge, the CDC is pursuing the following initiatives: (a) establishing a surveillance system to monitor the incidence and trends of these diseases; (b) selecting two study sites in which some of the basic epidemiology of the transmission of these diseases can be defined and compared to that of syphilis and gonorrhea. These sites will utilize an intensive surveillance network encompassing a significant proportion of both public and private sector providers, initiate clinical and epidemiologic studies to evaluate current syphilis and gonorrhea control programs, and also provide information about costs and benefits associated with controlling these other diseases; and (c) initiating a project to evaluate the incidence and etiologies of urethritis in men seen in the private sector. The results of these studies and research efforts conducted by NIAID in this area will be provided to States through consultations.

Since a majority of individuals from high-incidence communities acquire their first knowledge about symptoms and clinic services from peers, CDC is sponsoring peer counselling programs to tie into this grass-roots VD information network. The theory being tested is that young patients and potential patients will understand the significance of venereal disease within the community and respond better than they have to the activities of the control program if the diseases and the program to control them are described by their peers.

A national survey has been completed as the first phase of an effort to evaluate the extent and effectiveness of venereal disease education provided in the Nation's public and private schools. A survey questionnaire was mailed to nearly 16,000 schools representing all public and private schools throughout the country. A total of 6,518 (40.9%) of those schools queried responded. Responses indicate that 42% of the Nation's 102,000 schools provided some form of venereal disease education. Of the schools providing venereal disease information, about 30% utilize only noncurricula activities, and 70% provide units of instruction alone or units in combination with noncurricula activities. About three-fourths of the survey population are elementary schools and one-fourth secondary schools. Of the secondary schools, 71% offer units of instruction, whereas only 14.5% of the elementary schools do. The survey indicates venereal disease education is also more likely to be provided in schools with large student populations. Survey estimates indicate that 83% of schools with 1,500 or more students provide units of venereal disease instructions. Results also show that the availability of units of instruction are most often available in grades 8 and 10.

Nearly two-thirds of the schools which offer units of instruction include units in the Health Education curriculum. Regardless of course area, the units typically last 1-2 weeks. Fewer than one-fourth of the schools require the instructors for these units to have taken special training in venereal disease education. However, more than one-half of the schools which offer instructional units utilize health professionals as resources for classroom presentation.

Volunteer organizations, primarily the U.S. Jaycees and the National Association of Retail Druggists, have been equipped through training with the tools needed to develop broad-based citizen participation in programs designed to eliminate venereal disease. This training effort was designed to: (1) motivate volunteer organizations and individuals to work with State and local health departments in organizing community resources and talents to focus on VD control efforts; (2) expand efforts to promote and coordinate activities of national organizations and agencies which have the potential for local impact; and (3) train leaders with emphasis on the importance of getting together at the community level with representatives of all other organizations and with representatives of media, business, health, and education to develop a coordinated attack on venereal disease.

Based upon a survy of Regional Offices, 26 States and Puerto Rico have reported Jaycee accomplishments during the past 4 months. In some states, the Jaycees are involved in a number of different activities both statewide and locally. Thirteen states report that a voluntary group has been formed to coordinate all future activities. Jaycees are also involved in mass media programs, VD hotlines, speakers bureaus, state-level school instruction, and in expanding clinic services. Thirteen states report a broad range of awareness activities, from canvasing state legislators to dispensing VD frisbees. Of the 24 states not yet reporting accomplishments, 19 are in various stages of planning and/or meeting with local Jaycee chapters. Although no specific information is yet available on N.A.R.D. accomplishments, it has been noticed in many reports of Jaycee activity, that pharmacists are also acting as catalysts.

For the past 10 years, the efforts directed toward the private medical community have been threefold: To inform the private physician of the venereal disease control program; to elicit his cooperation in case reporting and in the epidemiologic process; and to provide him with diagnostic and treatment information. However, emphasis is now shifting to encouraging the private physician

to become more actively involved in the venereal disease control efforts by using his influence in the community to: Increase the number of diagnostic and treatment facilities available; support venereal disease instruction in the medical schools; and encourage local support and acceptance of venereal disease control efforts.

The Center for Disease Control continues to serve as the primary focus for operational research aimed at the practical application and evaluation of newly developed techniques in venereal disease control. The Center continues to be deeply involved with studies of disease epidemiology and control program methodologies; with emphasis on clinical and basic venereal disease research as they relate to these methodologies.

The benefits derived from many of these research projects are already being implemented into control efforts, while others are still being evaluated.

Realizing that control efforts for gonorrhea could not succeed without the availability and use of effective therapeutic regimens, the Center established nine sites to monitor therapy efficacy, organism antibiotic resistance and adverse patient drug reactions.

During FY 1975, the Nine-Center Cooperative Monitoring System for Gonorrhea Therapy evaluated the current CDC recommendations for the treatment of uncomplicated gonorrhea in 9,008 patients. All regimens continue to be highly safe and effective. Recurrence rates were less than 5 percent, and more than one-third of the recurrences were caused by reinfection. Although all geographic areas have some highly resistant strains of Neisseria gonorrhoeae, the system documented that resistance has not increased significantly in the past 3 years. Greater acceptance and application of CDC recommendations have thus helped to prevent selection of resistant strains.

Based on this monitoring system and other published studies, and after intensive review by therapy experts in mid-1974, minor revisions were made in the CDC recommendations for uncomplicated infection. New recommendations were also made for the treatment of some special areas of gonorrhea therapy: treatment of the penicillin-allergic patient, gonorrhea in children, and the complications of gonococcal infections. The system will continue to survey the antibiotic resistance of the gonococcus and the efficacy of the revised recommendations. Special studies will be conducted to ensure the continued efficacy of the recommendations in the special areas mentioned above, particularly for pelvic inflammatory disease.

A basic control model for gonorrhea is currently under development. The development process of this model has permitted venereal disease control programs to more clearly focus on unresolved or poorly understood facets of gonorrhea epidemiology. When completed, the model will serve as a management guide and tool to direct the best use of resources for maximum disease control results. The Center is also developing a stochastic model for the control of syphilis. When developed, this model will be used to predict the efficiencies of different control techniques.

Because of the multitude of outstanding diagnostic and therapeutic research in the clinical area, the CDC coordinates a wide variety of clinical investigations. These studies are directed primarily toward gonorrhea in women to identify the hidden reservoir of asymptomatic disease. These ongoing studies are designed to complement efforts in basic research by providing a field laboratory for new techniques, as well as a source of clinical materials for

research laboratories. The Center continues its involvement in the serological screening of selected populations, serological test evaluations, developing and evaluating diagnostic techniques, therapeutic trials, investigations of the long-term effects of both illness and therapy, definition of particular risk factors in host-parasite interactions, evaluation of major control efforts, the study and improvement in clinical services and other related areas of clinical research.

The Center has developed special areas for the control and study of venereal diseases which are designed to (1) establish adequate disease surveillance in the public and private medical sectors to assess the magnitude of the disease problem; (2) assess various disease control techniques which are designed to reduce the incidence and prevalence of disease; (3) Increase the efficiency of collecting patient data, expedite patient care and improve the gathering of epidemiologic information; and (4) perform selected studies on biologic and epidemiologic aspects of the sexually transmitted diseases.

These studies, just begun, involve the use of classical medical epidemiological techniques to identify high-risk subgroups within the general population. Once identified, these groups will be exposed to specific disease control techniques in new and novel ways to attempt to reduce the incidence and prevalence of disease in these groups. The impact of each innovation will be carefully measured.

In addition to its contributions to quality control and production of reagents, diagnostic-test development and proficiency testing the Center has contributed significantly to the understanding of the basic bacteriology and immunology of venereal disease. Accomplishments in basic research in the past few years include developing a standard selective culture medium for Neisseria gonorrhoeae; discovering and describing two types (Types I and II) of virulent colonies of Neisseria gonorrhoeae which are the source of gonococcal pili; measuring the in vitro antibiotic susceptibility of Neisseria gonorrhoeae from 1950 to the present; developing systems for the transport of Neisseria gonorrhoeae culture specimens; and applying gas liquid chromatography as a diagnostic test on body fluids.

Researchers at the Center for Disease Control have developed the FTA-ABS test for syphilis, reevaluated the CSF-FTA-ABS and FTA-ABS-IgM tests, and adapted the microhemagglutination test to syphilis serology. Gonococcal and syphilis infections were first established in animals by researchers at the Center; these animal models have been the basis for advances in understanding the pathogenesis and immunology of both diseases.

Because the in vitro cultivation of Treponema pallidum is necessary for refining serologic tests, and expanding our knowledge about the pathogenesis of syphilis, research is on-going to develop a defined medium for growing Treponema pallidum. Studies are being conducted for growing Treponema pallidum in a hemodialysis system and in various animal models.

Rapidly accumulating data indicate that other sexually transmitted diseases are growing in importance and require further attention and definition. The three most important of these diseases are nonspecific urethritis, genital herpes, and trichomoniasis. The Center is vigorously pursuing the development of comprehensive diagnostic laboratory procedures for venereal disease diagnosis, irrespective of cause; identifying the spectrum of agents most commonly

51-805 O - 75 -- 59

responsible for nongonococcal urethritis; elucidating the infectious etiology of penile ulcerations; and the development of a rapid diagnostic test for herpes.

Pelvic inflammatory disease is one of the most serious complications of gonorrhea in this country. Although major emphasis continues to be placed on preventing the transmission of the primary disease, renewed research efforts will be undertaken in FY 1976 to define additional risk factors, diagnostic techniques, and therapeutic modalities for this serious disease complication. Since recurrent PID is a major problem, studies will be initiated to evaluate means of preventing reinfection and relapse, which leads to most recurrent disease.

The role of the CDC laboratories in the maintenance of high-quality diagnostic laboratory services within the United States cannot be overestimated. Research in new developments and ongoing maintenance of methods for laboratory training, proficiency testing and reagent standardization will continue to receive high priority.

With a marked increase in the number of anecdotes concerning positive FTA-ABS tests in patients in whom syphilis was considered unlikely and in whom none of the factors thought to be associated with "false-positive" FTA-ABS reactions could be documented, the Center has begun to define and quantitate this phenomenon. Studies are also underway to determine the relative value of each of the serologic tests for syphilis.

During FY 1974, the Center continued to stimulate interest in venereal disease research through presentations at scientific meetings of medical societies and of researchers in specialties and disciplines which touch on venereal disease, less formal presentations to ongoing physician education groups, communications with scientists to review research protocols and to stimulate young investigators to enter the field, supporting studies directed at solving specific control program problems, and by serving as a focus for research activities related to venereal disease.

Because NIAID's major role focuses on the life and reproductive processes of the causative microorganisms of venereal disease, the Center coordinates with them all basic research in these areas.

Continued Federal support will ensure the continuance of the nationwide effort to control the spread of venereal disease. In conjunction with the Regional Offices, national leadership and technical assistance will be provided to increase the effectiveness of venereal disease control programs by refining disease intervention techniques. Emphasis will be placed upon strengthening intervention activities which are both medically and economically most effective in limiting the spread of disease through the treatment of infected individuals. Greater emphasis will be placed upon the simultaneous treatment of steady sexual partners, relying heavily on patient participation in the contact-referral process, thus reducing the likelihood of immediate reexposure to infection. Efforts will also be made to strengthen the epidemiologic management of individuals infected with syphilis to maximize the impact of contact referral and the epidemiological treatment of contacts on case prevention.

Venereal Disease Services to Indians

Venereal disease control services are provided to American Indians, Eskimos and Aleuts through venereal disease project grants awarded to State and local health departments. Approximately one-half of the 800,000 Indians living in the United States are eligible for health services provided through Indian Health Service facilities located in 24 States. In each of these States, venereal disease control efforts and services are coordinated between the State Health Department and individual Indian Health Service facilities.

In late FY 1972, as the national gonorrhea control program was being implemented, VDCD staff visited each of eight Indian Health Service Area Directors with representatives of the concerned State and local health departments. These meetings established the agreements necessary for supporting the extension of venereal disease control services in Indian Health Service facilities. Primarily, the resources in support of program expansion have been provided by Federal VD control grants through State Health Departments, with the Indian Health Service providing clinical services.

The major focus in program expansion has been to implement gonorrhea culture screening services. The number of cultures obtained from women increased from 38,443 in FY 1973 to 49,274 during FY 1974. The percentage positive during FY 1974 remained relatively high at 4.9 percent.

In addition to screening activities, syphilis and gonorrhea casefinding services are provided to infected individuals in an effort to interrupt the transmission of disease. Systems also exist to ensure that individuals with reactive serologic tests for syphilis receive adequate medical attention.

The VD control program which is the most complex in terms of both the level of disease incidence and the coordination effort required is in the Navajo Area. The program involves four States and three DHEW Regions. Resources for the control program in the Navajo Area are furnished by the States of Arizona and New Mexico. Federal grant support is furnished primarily through New Mexico. In addition to these resource inputs, the Indian Health Service recently awarded a contract to the Navajo Tribal Council to furnish outreach services in support of the VD control program.

VD Update for IHS Physicians

On September 9-10, 1974, a VD Update Course was presented to approximately 40 Indian Health Service clinicians at Gallup, New Mexico. The aim of the course was to provide an overview of venereal disease, particularly for the younger physicians, and to discuss specific problems encountered among Indian populations.

The course consisted of a series of 1-2 hour lecture/discussion periods, with an algorithmic approach, i.e., patient or physician problems were considered and a systematic approach was used to solve these problems. The topics included urethral discharge, vaginal discharge, penile lesions, positive syphilis serology, skin rashes and epidemiologic treatment.

This course has been modified and expanded to three days and has been offered to any other groups of IHS physicians in the United States.

Educational programs will be directed toward providing information about the venereal diseases to persons at high risk of acquiring infection, especially the venereal disease patient in an attempt to reduce the probability of re-infection. Also, education programs will emphasize the involvement of health care providers in all aspects of the venereal disease control effort. Physicians will be encouraged not only to diagnose properly and treat effectively, but also to involve patients in referring their sexual contacts to examination.

A methodology will be developed for evaluating the strengths and weaknesses of alternatives for delivering venereal disease education in school systems. This methodology will include the selection and delineation of innovative techniques, including knowledge, attitude and practice measurements, as well as the assessment of the practicality, efficiency and effectiveness of these and existing methods.

The Center will continue its involvement in the serologic screening of selected populations, serologic test evaluations, developing and evaluating diagnostic techniques, therapeutic trials, investigations of the long-term effects of both illness and therapy, definition of particular risk factors in host-parasite interactions, evaluation of major control efforts, the study and improvement in clinical services and other related areas of clinical research.

Research in gonorrhea immunology will include colony-typing systems to support epidemiologic investigations; serologic procedures, such as screening tests for the diagnosis of gonorrhea; identification of virulence factors and mechanisms of pathogenicity; host responses to complicated and uncomplicated gonococcal infections; and expanded animal-model studies of gonorrheal immune mechanisms.

The Center will develop activities to study the other sexually transmitted diseases which will be designed to: (1) establish adequate disease surveillance in the public and private medical sectors to assess the magnitude of these disease problems; (2) assess various disease control techniques which are designed to reduce the incidence and prevalence of these diseases; and (3) increase the efficiency of collecting patient data, expedite patient care and improve the quality of epidemiologic data.

11

NATIONAL INSTITUTES OF HEALTH

National Institute of Allergy and Infectious Diseases

The NIAID Effort in Research on Sexually-Transmitted Diseases

Since 1971, the National Institute of Allergy and Infectious Diseases (NIAID) has been developing a nationwide effort in research on venereal disease. Under NIAID support, 40 grantees, 2 program-project recipients, and 3 contractors are intensively investigating selected aspects of this public health problem, ranging from evaluation of new methods of diagnosing and treating venereal diseases to basic research on the life and reproductive processes of the causative microorganisms. In addition, nearly 20 young scientists, supported by NIAID fellowships or training grants, are receiving specialized research training under the direction of researchers experienced in the study of sexually-transmitted diseases. Through this multi-faceted approach, the Institute expects to provide a firm basis for developing improved methods of therapy and prevention.

Much of this research focuses on syphilis and gonorrhea, but the Institute recognizes that the problem is larger than those two infections. Symbolic of this recognition are two new program-project grants. These awards, initiated in 1974, support a multidisciplinary approach to the problem of venereal disease.

Dr. King K. Holmes, recipient of the first program-project grant, and his associates at the University of Washington are exploring the causes, manifestations, and treatment of non-gonococcal urethritis (NGU). Urethritis is an inflammation of the urethra, the canal carrying urine outside the body from the bladder. It is sometimes caused by the gonococcus, the microorganism causing gonorrhea, but not always. Other bacteria known as chlamydia and mycoplasmas are suspected of causing NGU and are being studied. Dr. Holmes' group is also investigating gonorrhea -- its epidemiology (the factors involved in its incidence), how the gonococcus causes disease, and the genetics of the gonococcus.

Under the second grant, Dr. Roger L. Nichols and coworkers at the Harvard University School of Public Health are comparing the role of ten infectious microorganisms in genital infections. The agents include the gonococcus and other bacteria, cytomegalovirus, chlamydia, herpes simplex virus, mycoplasmas, Trichomonas vaginalis, and certain fungi.

Gonorrhea

Gonorrhea, long considered the most common sexually-transmitted disease, is caused by a bacterium known as the gonococcus. The scientific name is Neisseria gonorrhoeae.

Typically, the gonococcus infects the lining of the genitourinary tract. In males, this involves an acute, purulent (with pus) infection of the urethra. In females, infection of the urethra and the cervix (the opening of the womb) is usual. Newborn children may acquire a purulent infection of the eyes from an infected birth canal in the mother. To prevent this and other eye infections, silver nitrate solution is placed in the eyes of all infants immediately after birth. Complications of gonococcal infection often include sterility and arthritis (particularly in the female) and can sometimes result in infection of the brain (meningitis) or heart (endocarditis).

Recent changes in sexual practices may be related to findings by physicians of gonococcal infections in such areas of the body as the rectum and throat. NIAID grantee Dr. Donald Kaye and others at the Medical College of Pennsylvania and the Philadelphia Veterans Administration Hospital recently surveyed a small

group of pregnant women. They found that, of those patients with some form of gonococcal infection, 35.5 per cent had infection only in the throat. This suggests the importance of testing for gonococcal infections in other parts of the body besides the genitourinary tract.

The early symptoms of gonorrhea usually begin within two to eight days after exposure by sexual contact. However, many people -- especially females -- may have no apparent symptoms of the disease until much later. Such symptom-free infections may be one reason for the current uncontrolled spread of this disease.

The gonococcus has been recognized for almost 100 years, but scientists still know little about the organism -- for example, its growth needs, its mechanism of action, and its requirements when being transported for study.

In order to answer these questions, an animal must be found which can serve as a model for the human infection. The chimpanzee is a good animal model, but is expensive and difficult to obtain. NIAID grantees have found the chick embryo and rabbits also are promising animal models.

A culture system studied by Dr. Zell A. McGee at Vanderbilt University may circumvent the difficulties investigators have had in infecting the mucous membranes of experimental animals. Dr. McGee uses small sections of the human fallopian tube maintained in organ culture. The mucous membrane surfaces of the fallopian tubes have cilia, hair-like structures, which beat vigorously in organ culture for 10 to 14 days if the cultures are not infected. If they are infected with virulent gonococci, a rapid decrease in this ciliary activity is noted.

Using this model, the Vanderbilt scientists demonstrated differences in the virulence of gonococcal strains by showing differences in how quickly they decrease ciliary activity. By relating the presence or absence of various characteristics of gonococcal strains to the virulence of the strain in this organ culture, researchers should be able to define the factors likely to be important to its ability to cause disease. Knowledge of such virulence factors might, in turn, aid the development of new methods of preventing and treating gonococcal infections.

Structure and Virulence of Gonococci. There are four types of gonococci, divided according to their appearance and growth in laboratory culture media. Only types 1 and 2 appear to be "infectious" or "virulent" strains, while types 3 and 4 are not usually associated with disease. Scientists believe there is a correlation between this virulence and the presence of "pili," microscopic, hair-like appendages on the surface of types 1 and 2, but not on types 3 and 4.

The biochemical and genetic basis for this correlation is not clearly understood. Dr. John Swanson, one of the discoverers of pili and now an NIAID grantee at the University of Utah College of Medicine, recently found that piliated type 1 gonococci attached to 50 per cent of human sperm after they were incubated together in test tubes for 15 minutes at 95°F. Nonpiliated type 4 gonococci attached to only 23 per cent of sperm under the same conditions. This lends support to the theory that some gonococci "hitchhike" on sperm, traveling through the male and female reproductive systems and causing local spread of infection.

Dr. Swanson has also studied the role of pili in interactions between gonococci and human leukocytes (white blood cells which seek out bacteria and kill them). He has found that pili seem to have little to do with whether leukocytes kill gonococci or not, but that another surface factor, distinctly different from pili, may be the crucial influence in this interaction. This factor, thought to be a protein, is called "leukocyte-association factor (LA)." It may be present on the surfaces of either piliated or non-piliated gonococci. LA-positive organisms are killed in great numbers by leukocytes, but LA-negative organisms usually are not. In turn, the presence or absence of LA has no effect on the attachment of piliated gonococci to certain body cells.

13

A number of investigators have suggested the existence of strain-specific antigens associated with the gonococci. (Antigens are proteins capable of eliciting the production of protective substances known as antibodies.) Dr. William A. Pierce of Tulane University has identified one "virulence-associated antigen" or "F62 antigen", which appears to differ from other previously identified virulence factors. It was found in only one (F62) out of twelve virulent gonococcal strains studied. Dr. Pierce is continuing to study this antigen as a candidate for use in a vaccine and will look for similar virulence antigens in other gonococcal strains.

Screening Tests. Following the discovery of the pili, a sensitive radioimmunoassay test for detecting gonococcal infections was developed by Dr. Thomas Buchanan and Emil Gotschlich of the Rockefeller University and by Dr. Swanson at Utah. The Rockefeller scientists are continuing their evaluation of this test. They have been able to confirm their earlier findings of the test's usefulness in asymptomatic women and have also discovered that the test may be applied to men with pharyngeal (throat) gonococcal infections. These investigators have also been working on improving the yield and purity of the gonococcal pili antigen used in the test so it can be made available commercially to physicians.

Because effective gonococcal therapy depends on early identification, Dr. Harry E. Morton, an NIAID grantee at the Hospital of the University of Pennsylvania, has developed a rapid screening test for detecting the gonococcus, either living or dead, or its soluble products. Specially prepared antibodies are chemically bonded to stabilized sheep red blood cells. These antibody-coated red blood cells can then be used in either of two ways -- in the indirect microhemagglutination test or in identification of bacterial colonies. Either procedure is more efficient than the present method, which takes four days for growing, isolating, and identifying the organisms. These new tests require only small amounts of materials, make use of ordinary equipment found in most bacteriological laboratories, and do not require highly skilled personnel. Antibody-coated cells may also prove useful for identifying colonies of Mycoplasma hominis, another microorganism which may be transmitted sexually.

Grouping Gonococci. Being able to divide the strains of the gonococcus into a few groups according to blood properties (serotypes) would facilitate studies of immunity to this bacterium and epidemiological investigations of the disease.

Dr. Gotschlich has combined a study of the basic structure of the gonococcus with work on identifying its serotypes. Like many bacterial organisms, the gonococcus has a cell wall consisting of two membranes. Dr. Gotschlich and his colleagues have successfully separated the two membranes and have now identified 15 different proteins in the outer membrane. Antisera (serum samples containing antibodies to a particular protein) were prepared to 12 of these and used to serotype gonococci.

Antisera specificity appears to be related to the major outer membrane protein of each serotype. For instance, of 154 gonococcal strains isolated in the New York City area, over 98 per cent could be classified into seven serologically distinct groups. Less than 60 per cent of strains isolated overseas could be identified using antisera prepared against New York strains. Preliminary results also exhibited no difference between serotypes of strains from people with widespread disease or non-urogenital infections and from those with the usual urogenital infections. The fact that, to date, all strains from pairs of sexual contacts have been of the same serotype suggests that this property is a stable one which will be useful in tracing dissemination of this disease in the community.

Problems of Antibiotic Resistance. For more than 30 years the treatment of choice for gonorrhea has been penicillin. Three years ago, however, the Public Health Service doubled its recommended dose of penicillin in response to increased reports by physicians of treatment failures.

Because of resistance and because an unknown number of Americans are allergic to penicillin, other antibiotics must sometimes be used against gonococcal infections. Unfortunately, there are reports of strains also becoming resistant to the "second line" antibiotics -- spectinomycin, kanamycin, and tetracycline.

Scientists are especially anxious, therefore, to gain an understanding of the mechanisms by which gonococcal organisms develop resistance. NIAID grantee Dr. P. Frederick Sparling at the University of North Carolina has established, for the first time, the basic genetic events involved in the gradual development of resistance to antibiotics. He showed that penicillin resistance is due to the additive effects of mutations of three genes. He found no evidence of antibiotic-inactivating enzymes, but he showed that resistance to several other antibiotics (tetracycline, chloramphenicol, and erythromycin) is also due to additive effects of genes. All of these genes were found on chromosomal DNA (the hereditary material of the cell).

L-Phase Variants. Some gonococci, when exposed to penicillin, become L-phase variants. This means they are not actually killed, but rather lose their rigid, shell-like cell walls and continue to multiply as tiny microbes. Since penicillin acts by preventing cell wall formation, it does not harm these defective variants.

Dr. McGee at Vanderbilt University Medical School has been studying the growth and activities of these organisms. He has found that they survive and reproduce in levels of penicillin greater than that ordinarily used in gonorrhea therapy and that they are undetected by routine bacteriological techniques. For these reasons, scientists suspect that L-phase variants may play a role in gonorrhea treatment "failures" or in "non-gonococcal" urethritis.

Exploring this theory, Dr. McGee studied the effect of various antibiotics on the induction and survival of gonococcal L-phase variants. Penicillin, ampicillin, and amoxicillin induced gonococcal L-phase variants, but tetracycline and spectinomycin inhibited the variants at concentrations approximately the same as those that inhibited the complete bacterial form. These studies help to identify those clinical situations in which attempts to isolate L-phase variants might be most fruitful and to identify those drugs likely to be effective if gonococcal L-phase variants are shown to be playing a role in the infectious process.

Disseminated Gonorrhea. Another NIAID grantee is attempting to determine if changes in the body's response to gonococci are responsible for the spread of gonococcal infections. Sera were collected from women during different times in the menstrual cycle and tested simultaneously for killing activity against gonococcal types 1, 2, and 4. Dr. Abraham I. Braude, University of California, San Diego, found distinct differences in the blood's ability to kill these types. Type 2 was consistently more resistant to killing by serum than type 4 at any time during the menstrual cycle. This not only fits in with type 2's greater ability to establish human infection, but also suggests that it might be more likely to produce disseminated disease (spread throughout the body).

In addition, variations in the ability of serum to kill gonococci were found at different times during the menstrual cycle. Such variations might mean that during certain phases of the menstrual cycle, dissemination of gonococcal infection would be more likely to occur. Further studies are needed in order to correlate given phases of the cycle with specific levels of bactericidal activity.

Therapy and Prevention of Gonococcal Infections. In a collaborative study in Seattle, scientists -- supported by NIAID, CDC, and others -- found that a single oral dose of a new semisynthetic penicillin, amoxicillin, seemed to be as effective in treatment of gonorrhea as the recommended Public Health Service regimen of ampicillin and probenicid. Drs. Walter Karney and King K. Holmes of the University of Washington and Marvin Turck of Harborview Medical Center also decided that

amoxicillin, if given with probenicid or in two divided doses four to five hours apart, might be even more effective than comparable doses of ampicillin.

Although administration of a vaccine might be an ideal way to control gonococcal infections, development of conventional vaccines must wait for expanded knowledge about the basic workings of the gonococcus and its effect on the human body. A different approach to prevention is being explored by Dr. Donald Kaye who is studying bacterial interference — the ability of the growth of one type of bacteria to inhibit that of another. In laboratory studies, Dr. Kaye found that 14 of 20 strains of Staphylococcus epidermidis, a non-disease-causing bacterium commonly found on the skin, demonstrated good to excellent inhibition of Neisseria gonorrhoeae. Preliminary results show that, in several women with gonorrhea, the presence of inhibitory S. epidermidis in one genital site correlated with low numbers of gonococci or no gonococci at that site. Correspondingly, high titers of gonococci were found in other genital sites where there were low titers or no S. epidermidis. Further studies on the mechanisms of this interference could lead to prophylactic and therapeutic measures for gonorrhea.

Syphilis

Syphilis is caused by Treponema pallidum, a spiral-shaped, very mobile bacterium known as a spirochete. Like gonorrhea, syphilis is acquired through sexual intercourse with a person who is in the infectious stage. Syphilis may also be acquired by an unborn child from an infected mother.

There are several stages of syphilis. In the primary stage, the first symptom is a small sore at the site of infection. This sore may appear 10 to 90 days after exposure. If the disease is not treated, a rash may develop three to six weeks later during the secondary stage. The rash may cover the body or appear only on the hands or feet. Like the first stage of syphilis, outward signs of this secondary stage will disappear without treatment, but meanwhile the spirochetes will have begun to invade any of several organs in the body.

During these first two stages, the syphilis organism is highly infectious. If untreated, the infectious state of the disease will persist, through a stage known as early latent syphilis, for about two years from the time of initial infection. In this early latent stage, the organisms, after a long period of dormancy, begin their attack on the heart, brain, and spinal cord. Untreated syphilis can cause mental illness, blindness, heart disease, and even death.

Biology of Spirochetes. A principal hindrance to research on T. pallidum is the inability of scientists to grow this bacterium outside of man -- the only animal that naturally acquires syphilis. The organism has proved so elusive that laboratory cultivation of it in a tissue culture system has escaped researchers for all of the 70 years since its discovery.

During this past year NIAID initiated a modest contract research program to stimulate more syphilis research and bring new investigators to the field. Under contract, Dr. James Miller, University of California, Los Angeles, Dr. Howard Fieldsteel, Stanford Research Institute, and Dr. Howard Jenkin, Hormel Institute of the University of Minnesota, are working on the problem of laboratory cultivation of T. pallidum. They are testing various methods never before applied to culture of this organism and are studying its enzymes to determine this treponeme's metabolic and nutritional requirements.

For many years T. pallidum has been considered anaerobic, that is, living and growing only in the absence of oxygen. Then, in 1974, NIAID grantee Dr. C. D. Cox at the University of Massachusetts made a discovery which may facilitate laboratory cultivation. He showed that T. pallidum consumes oxygen at a rate similar to that of the known aerobic (growing only in the presence of oxygen) spirochete Leptospira. Although his data contradict current theory,

Dr. Cox believes the evidence is strong[16] that oxygen is, indeed, required for this organism's reproduction and growth. He is now exploring this subject further in an effort to grow T. pallidum.

Onee large quantities of T. pallidum can be grown, work on a vaccine to prevent syphilis can proceed more easily. First, however, it will be necessary to obtain the bacteria free of all tissue contaminants, and NIAID grantee Dr. Joel B. Baseman at the University of North Carolina is investigating ways to purify T. pallidum cultures. After extracting virulent syphilis spirochetes from infected rabbit testes, he subjects them to a purification technique known as velocity sedimentation in gradients of Hypaque, a high density, low viscosity material. The rabbit tissue components settle out more rapidly than the treponemes. Studies have shown that the treponemes retain their general structural characteristics and ability to induce antibody production, although a loss of motility and infectivity does occur. Not only will such purified treponemes be useful for vaccine research, but more detailed biochemical studies of the bacterium are now possible. The results of Dr. Baseman's project also suggest that either more than one treponeme is involved in the disease or that there is an early and a late stage in the treponemal growth cycle.

Immunity and Vaccine Development. An understanding of the mechanisms of immunity -- the way in which the host protects itself against invading organisms -- is a necessary base for the development of a vaccine. However, much remains to be clarified about the role of immunity in syphilis.

Basically, the human body has two types of immunity -- humoral immunity, which depends on antibodies that circulate in the bloodstream and are activated against foreign materials; and cellular immunity, which utilizes various types of protective cells that can be mobilized to destroy foreign materials. In syphilis, infection progresses through the primary and secondary stages despite the presence of large amounts of circulating antibody to the treponemal organism. This implies that the cellular immune system plays an important role.

Studies aimed at elucidating, in syphilis, the role of the two defense mechanisms are underway at several NIAID grantee institutions. For example, Dr. Daniel M. Musher at the Baylor College of Medicine has obtained evidence that the initial infection produces a suppression of immunity that persists through the secondary infection. This would help explain why people continue to have syphilitic lesions and to be infectious for long periods of time, despite the fact that antibodies have developed within the first few weeks. Interestingly, in experimental rabbits, the syphilis infection is self-limited and rapidly subsides, showing no immune suppression.

Dr. Musher pursued his suspicions about the suppression of cellular immunity by studying the response of certain white blood cells, known as lymphocytes, to T. refringens, a non-virulent bacterium sharing certain common antigens with other treponemes, including T. pallidum. The response of lymphocytes from syphilis patients was indeed suppressed when these cells were exposed to T. refringens.

Researchers believe, however, that T. pallidum infection eventually stimulates cell-mediated immunity which may be instrumental in inducing the latent period of syphilis. Dr. Musher found evidence to support this theory by studying the response of T. pallidum-infected rabbits to Listeria monocytogenes, another bacterium capable of infecting humans. Enhanced ability to suppress the growth of Listeria was detected in the livers of these rabbits three to five weeks after infection with T. pallidum. This period corresponds with the onset and regression of the generalized syphilitic eruption.

The role of humoral immunity has been studied by other investigators. They have found that antibodies can modify the early clinical disease in rabbits by prolonging the incubation period. Dr. Russell S. Weiser, an NIAID grantee at the University of Washington, is now studying rabbit blood to determine which

immunoglobulins or antibodies are protective. Early results indicate that protection is associated with more than one immunoglobulin. Dr. Weiser hopes, if he can show that human serum is protective in the rabbit, to study protective antibodies in the blood of patients suffering from different stages of acquired and congenital syphilis.

Herpes Simplex Virus Infections

A sexually-transmitted disease of increasing prevalence and great concern is herpes simplex virus type 2 infection. The herpes simplex virus -- herpesvirus hominis -- has been shown to exist in two strains -- types 1 and 2. Type 1 infections are commonly found above the waist, as in "fever blisters", and type 2 below the waist, as in genital infections. Although not as serious as gonorrhea or syphilis, genital herpes infections may produce acute, severe pain and temporary disability. Like fever blisters, these infections tend to recur.

In addition, herpes virus infection of the female genital region may cause disseminated herpes virus infection of the newborn -- frequently a fatal or crippling disease. Obstetricians, when they diagnose genital herpes in an expectant mother, often make plans for delivering the baby by caesarean section to avoid exposure to the virus.

Genital herpes virus infection may also be linked to development of cervical cancer. The National Cancer Institute is currently investigating the relationship of herpes infection to cervical and other types of cancer.

As in almost all viral infections, there is no specific cure for herpes infection. For this reason, the Infectious Disease Branch of NIAID is evaluating, under contract, an antiviral chemical known as Ara-A (adenine arabinoside) for treating serious herpes infections, such as herpes encephalitis. Twenty-two centers throughout the country are participating in this study.

Another approach to the management of recurrent herpes virus infections is the use of the tuberculosis vaccine (BCG). This preparation stimulates cellular immunity which is thought to be the mechanism underlying resistance to herpetic infection. In one study, NIAID grantee Dr. Carl L. Larson and co-workers at the University of Montana, Missoula, gave BCG to 15 women. All experienced a dramatic decrease in the frequency of recurrent herpetic infections. Lesions recurred more frequently in those study patients who became pregnant following vaccination than in the other women, however, which supports the theory that pregnancy itself inhibits cellular immunity.

Other Sexually-Transmitted Diseases

Other organisms causing sexually-transmitted diseases are also being studied by NIAID grantees.

Chlamydia are a group of microorganisms, one of which causes trachoma, a serious eye infection. Some scientists believe that chlamydial infections of the eye and of the genital tract often go unnoticed because physicians in this country are not used to encountering them. Although effective tests have recently been developed, they are not yet available to most physicians.

One NIAID grantee who is trying to determine the true extent of genital chlamydial infections is Dr. Julius Schachter of the University of California, San Francisco, School of Medicine. He found that in more than 1600 patients attending selected clinics in the San Francisco area, chlamydial infections represented the most common venereal disease.

Dr. Almen L. Barron of the State University of New York in Buffalo is exploring possible candidates for an animal model for chlamydial infection. He is currently investigating different ways of infecting guinea pigs with either the agent of lymphogranuloma venereum or guinea pig inclusion conjunctivitis, both chlamydial infections.

Trichomonas vaginalis, a protozoan, is a common cause of parasitic infection in the United States. An estimated 2.5 to 3 million Americans have this infection, trichomoniasis, each year. In humans, this organism only infects the genitourinary tract, causing vaginal lesions and a discharge in females. In men the infection is usually asymptomatic. Direct sexual contact is the most common mode of transmission for this disease; at birth, the newborn may acquire a genitourinary infection from an infected mother. Also since this parasite can survive up to 24 hours wherever there is moisture, non-sexual direct contact with a recently contaminated object may sometimes lead to infection.

Although trichomoniasis does not lead to serious complications, it is personally annoying and costly to the nation in terms of increased health care expenses and lost time from work or school. Furthermore, the presence of trichomoniasis can confuse the evaluation of a Pap smear for cervical cancer detection. This parasite can make the cells observed during this test appear atypical, often resulting in a false-positive test reading.

In addition to the work on Trichomonas vaginalis in the Harvard program-project study, NIAID grantee Dr. Miklos Muller at Rockefeller University is investigating the chemistry of this parasite. By studying the enzymes and subcellular parts of Trichomonas, he hopes to better understand its life processes.

Mycoplasmas are other microorganisms which have been implicated in sexually-transmitted diseases. Dr. William M. McCormack of Boston City Hospital and Harvard Medical School is studying the role of mycoplasmas in pelvic inflammations, nongonococcal urethritis, and other venereal diseases.

Another virus of potential importance in venereal infections is cytomegalovirus. Early results from the NIAID program-project study recently initiated at Harvard University suggest that antibodies formed in response to this virus can be found in secretions from the female reproductive tract. They also indicate that a test, the indirect fluorescent antibody test, is an effective way of detecting these antibodies.

As research continues, other microorganisms may be found to be venereally transmitted. In recent years sexually-transmitted diseases have spread rapidly, and unless treated quickly, caused serious complications in both males and females. Just as important, however, are the possible effects of many of these diseases on unborn children -- sometimes even permanent damage or death. Research, such as that supported by NIAID, should provide the knowledge needed to help control sexually-transmitted diseases.

DESCRIPTION OF ADAMHA RESEARCH AND TRAINING GRANT PROGRAMS

REGULAR RESEARCH GRANTS AND CONTRACTS

1. Purpose of program

The objective of this program is to develop new knowledge and approaches to the causes, diagnosis, treatment, control, and prevention of mental diseases, alcoholism and drug abuse through basic, clinical, and applied research, investigations, experiments, demonstrations, and studies. Areas of special interest include alcoholism, drug abuse, depression, child mental health, crime and delinquency, minority mental health, aging and schizophrenia. In addition, "Small Grants", provide support to develop and test opportunity; to analyze collected data or to carry out exploratory studies.

2. Funds

1967 obligations	$60,664,000
1968 obligations	66,823,000
1969 obligations	73,376,000
1970 obligations	70,387,000
1971 obligations	75,156,000
1972 obligations	84,256,000
1973 obligations	79.498,000
1974 obligations	110,187,000 1/
1975 estimate	91,131,000 2/
1976 estimate	90,300,000

3. Present stage of development

In 1975 the ADAMHA budget provides for continuing support of research projects as well as new awards in the following fields: alcoholism, drug abuse, behavioral sciences, clinical research, applied research, psychopharmacology research, epidemiology, services development, crime and delinquency, metropolitan problems, minority mental health, and other social programs. As shown in the above table, the extent of this support has grown from $60,664,000 in 1967 to $90,300,000 in 1976.

4. Plans for the future

In order to promote the mental health of the Nation, it is necessary to continue improving our base of knowledge by means of a continuum of scientific investigations from basic, normative studies to community-based evaluations of new approaches to the care of the severely ill.

1/ Includes $13,806,000 from FY 1973 released funds.
2/ Includes $1,175,000 from FY 1973 released funds.

In 1976, the National Institute of Mental Health will emphasize research in child mental health, aging, schizophrenia, crime and delinquency, minority mental health, depression, and services development. In the area of drug abuse, the National Institute on Drug Abuse will emphasize: development of improved therapeutic knowledge for treatment; epidemiology of drug abuse; and, adverse effects of drug use. In alcoholism, the National Institute on Alcohol Abuse and Alcoholism will devote particular attention to studies on the neurology of alcoholism. Studies will be directed at understanding the effects of alcoholism on electrophysiological events, on nerve cell physiology, and on neuroendocrine aspects.

HOSPITAL IMPROVEMENT GRANTS

1. Purpose of program

The objectives of this program are to provide grant support to State mental hospitals for projects which will improve the quality of care, treatment, and rehabilitation of patients; and develop relationships with community programs for mental health.

2. Funds

1967 obligations	$9,000,000
1968 obligations	10,490,000
1969 obligations	10,499,000
1970 obligations	7,500,000
1971 obligations	6,900,000
1972 obligations	6,751,000
1973 obligations	5,900,000
1974 obligations	6,795,000 1/
1975 estimate	4,900,000 2/
1976 estimate	3,700,000

3. Present stage of development

By the end of June 1974, a total of 280 Hospital Improvement Program grants had been awarded to 197 of the hospitals eligible to participate in this grant program. In all States at least one State hospital has applied and been funded.

4. Plans for the future

The 1976 President's Budget provides for continuing support of 37 awards made in previous years. The decreased funding level in FY 1976 reflects the continued phasing out of this program. Since this program has achieved its goal of demonstrating innovative treatment methods in every State of the Union, it is felt that this area of activity can now be assumed at the State and local level.

1/ Includes $839,000 from FY 1973 released funds.
2/ Includes $161,000 from FY 1973 released funds.

3

TRAINING GRANTS AND CONTRACTS

1. Purpose of program

The objective of this program is to increase the number and improve the quality of people working in the areas of mental health, mental illness, alcoholism and drug abuse; and to develop and evaluate models of innovative training for new types of mental health personnel. Training grants are awarded providing direct support to public and nonprofit institutions to help defray teaching costs and to make financial assistance available to students being trained. Training contracts are awarded by the National Institute on Drug Abuse to fund short term regional training centers and the National Drug Abuse Training Center in Washington, D.C.

2. Funds

1967 obligations.....	$90,422,000
1968 obligations.....	96,518,000
1969 obligations.....	109,014,000
1970 obligations.....	107,500,000
1971 obligations.....	107,650,000
1972 obligations.....	114,063,000
1973 obligations.....	88,363,000
1974 obligations.....	146,590,000 1/
1975 estimate.....	77,488,000 2/
1976 estimate.....	49,881,000

3. Present state of development

Efforts in manpower development over the past two decades have been concentrated in the mental health core disciplines of psychiatry, psychology, psychiatric nursing, and social work. At the time these activities originated, the amount and competence of available mental helath professional manpower, were inadequate to meet the needs of post-war America. At the present time, although shortages still exist, professional manpower in the field of mental health appears to have a sufficient base with which to compete in the market place under the normal laws of supply and demand. During FY 1972, the Federal Government intensified its efforts to provide treatment services for all narcotic addicts desiring treatment. This resulted in direct Federal funding of a nationwide network of treatment projects. This created a large demand for trained personnel to work in these projects. This demand has been met through training received at regional training centers and the National Drug Abuse Training Center.

1/ Includes $26,677,000 from 1973 released funds.
2/ Includes $4,760,000 from 1973 released funds.

4. Plans for the future

It is felt that training programs have been developed to the point that they are now able to compete in the open market place for funds, and that students should no longer receive Federal subsidies for their education - particularly in those professional fields for which there is a relatively high earning potential. Accordingly, beginning in FY 1975, all training grants activities of ADAMHA will be gradually phased out. No new awards are projected for any training grants during FY 1976. In addition, the Drug Abuse Regional Training Centers will be eliminated in FY 1976. Responsibility for training health services delivery personnel who work in drug abuse treatment centers is being shifted to the States. Funding will be available through formula grants to States.

REGULAR RESEARCH FELLOWSHIPS

1. Purpose of program

The purpose of this program is to increase the supply of manpower available for research and teaching by providing qualified individuals with support for training in health related fields. There are two major categories of regular research fellowships: predoctoral and post-doctoral.

Predoctoral fellowships provide assistance to individuals who have a bachelor's degree and two years of post-baccalaureate training for further training leading to a doctoral degree. Post-doctoral fellowships support advanced training for an individual who has already earned a Ph.D., M.D., D.D.S., or equivalent degree.

2. Funds

1967 obligations.....	$5,694,000
1968 obligations.....	5,778,000
1969 obligations.....	5,976,000
1970 obligations.....	5,805,000
1971 obligations.....	3,707,000
1972 obligations.....	3,498,000
1973 obligations.....	882,000
1974 obligations.....	2,075,000
1975 estimate.....	4,899,000 1/
1976 estimate.....	5,477,000

3. Present state of development

The Research Fellowship Program has developed a basic cadre of research scientists who contribute both to the understanding of

1/ Includes $1,950,000 from 1973 released funds.

the etiology and incidence of mental illness and to the prevention and correction of such disturbances.

4. Plans for the future

The FY 1976 budget request contains funding to support all continuation requirements. The NIMH request contains sufficient funds to make approximately 100 new post-doctoral awards.

RESEARCH CAREER PROGRAM

1. Purpose of program

This program is designed to increase the number of full-time career opportunities for scientists with superior potential ability in the health sciences. The program consists of two types of awards: career awards and research scientist awards. Career awards support established investigators of high competence for the duration of their careers. Research scientist awards support qualified scientists who have three years or more of relevant post-doctoral research or professional experience and who require additional training in preparation for careers in independent research. Awards are normally made for five years and may be extended for not more than a total of ten years.

2. Funds

1967 obligations.....	$3,430,000
1968 obligations.....	4,377,000
1969 obligations.....	4,539,000
1970 obligations.....	5,061,000
1971 obligations.....	4,991,000
1972 obligations.....	5,045,000
1973 obligations.....	4,621,000
1974 obligations.....	4,406,000
1975 estimate.....	3,562,000
1976 estimate.....	3,562,000

3. Present stage of development

The Research Career Program has developed research capacity in the psychiatric profession, engaged investigators from a variety of the behavioral and biomedical sciences in mental health research, and fostered interdisciplinary research on mental health programs.

4. Plans for the future

The FY 1976 budget contains funds to support continuation commitments and one new award.

DESCRIPTION OF EACH NIH GRANT ACTIVITY AND/OR PROGRAM

The data includes the Division of Environmental Health Sciences beginning with 1967 when it became an NIH component. It does not include the activities of the National Library of Medicine, although they became a component of NIH in 1970.

REGULAR RESEARCH GRANTS
(All NIH Institutes and Research Divisions)

1. Purpose of program

To provide grant support of research in health, medicine, and allied fields with the major objectives (1) of continuing existing programs of research, (2) of expanding medical and biological research activities in universities, hospitals, laboratories, and other public or private institutions, and (3) of stimulating new investigations in fields needing exploration. The grants range from support of smaller, discrete, and circumscribed projects, which are defined as project grants to support of broad programs which integrate the research interests of several investigators, and which are called program project grants.

2. Funds

1967 obligations	$448,431,000
1968 obligations	461,327,000
1969 obligations	454,949,000
1970 obligations	437,317,000
1971 obligations	487,908,000
1972 obligations	584,723,000
1973 obligations	608,249,000
1974 obligations	765,121,000
1975 estimates	645,178,000
1976 estimates	676,448,000

3. Present stage of development

NIH research grant activities began modestly in 1938 with awards through 1945 by the National Cancer Institute amounting to less than $100,000 annually. In 1946 legislative authority was enacted which permitted support of a broad program scope in research related to health, medicine and related sciences. This support could not exceed the authorization of $780,000. In 1948 the National Heart Institute was authorized, other Institutes were established, and NIH became the National Institutes of Health. The research grant programs grew steadily, reaching $998 million in fiscal year 1974. In the late 1950's special research grant activities and programs were formulated for research centers and other large interdisciplinary program projects which now complement the traditional single project research grant. The current research grants represents a mix of regular grants (for which funding is shown above) and special research grants (descriptions and funding in the following pages). Under budget limitations, the rate of growth slowed down in the late 1960's, and in 1969 it became necessary for NIH to negotiate individual competing project awards downward by an average of approximately 10% per year below the 1968 level. This action was taken because of the cutback in Federal spending required in the Revenue and Expenditure Control Act of 1968. Subsequently, the practice was necessary in both 1970 and 1971. The 1971 increase in funding shown went largely for new activities or programs, whereas it was necessary to continue to negotiate reductions of ongoing projects. New and special targeted programs (characterized by the term "special initiatives") for

research related to cancer, heart, blood and lung disease, sickle cell anemia, digestive diseases and others have been initiated in recent years. Additionally, there has been continuing support for projects of high quality across a broad spectrum of health fields. A significant part of the increases has gone to these special initiatives. In a few Institutes in 1973 it was necessary to negotiate reductions of some grants. There was a similar plan in effect early in fiscal 1974 but with the release of FY 1973 funds late in FY 1974, and with the 1974 increase there was a limited amount of negotiated reductions. The President's rescission proposal for FY 1975 contemplated a 5% reduction in noncompeting grants--which was effected where prior negotiations had not already precluded such a step--and the proposal also provided for a 25% reduction in competing grants (awarded after September 1974).

4. Plans for the future

The NIH believes that medical research should continue to receive major support as long as this country is faced with major crippling and killing diseases and conditions. The vigorous national scientific attack on cancer and heart, lung and blood diseases will continue. Support will also be provided through the research grant mechanism for projects, both fundamental and applied, addressed to the broad range of health and disease problems for which the NIH has research responsibility.

GENERAL RESEARCH SUPPORT GRANTS
(Division of Research Resources)

1. Purpose of program

The General Research Support Program provides flexible institutional funds on a formula basis to non-federal public, private and non-profit institutions actively engaged in biomedical and behavioral research such as health professional schools, universities, hospitals, research organizations, etc. The amount of each award is based on the total amount of NIH and National Institutes of Mental Health Research project grants received by each institution in the preceding fiscal year. The funds awarded may be spent by the recipient institution for "direct costs" of health-related research using on-site judgment regarding emphasis, specific direction and content of activities supported. This program enhances the effectiveness and efficiency of biomedical and behavioral research by enabling the grantee institutions to respond quickly and effectively to emerging opportunities and unpredictable requirements, to enhance creativity, to encourage innovation, to provide for pilot studies, and to improve research resources, both physical and human.

2. Funds

1967 obligations	$ 51,700,000
1968 obligations	59,674,000
1969 obligations	60,700,000
1970 obligations	57,677,000
1971 obligations	54,200,000
1972 obligations	53,212,000
1973 obligations	21,124,000
1974 obligations	78,725,000 1/
1975 estimates	-0- 2/
1976 estimates	-0-

[1] $45,149,000 is 1974 funds and $33,576,000 is from 1973 released funds.

[2] $43,000,000 would be available if Congress disapproves the rescission. (See also the Minority Biomedical Support program previously shown as a component of the general research support program.)

3. Present stage of development

In 1975 General Research Support grants would have provided support for 461 health professional schools, other academic institutions, hospitals, research institutions, laboratories, centers and certain other nonprofit research organizations heavily engaged in health related research. This would have involved an estimated 9,000 people in almost 8,000 activities. If the rescission proposal of $43 million (the amount appropriated by Congress) is upheld, then total support will have been withdrawn from this program.

4. Plans for the future

There are no funds available in the 1976 President's budget for the General Research Support Program, however, the Congress during the 1975 appropriation hearings observed that changed circumstances and the passage of time while not diminishing the need for these grants may have changed their functions somewhat. They requested that the Division provide them with a report describing plans for new formula and guidelines, relating to eligibility, allocation, and usage of these funds. This report is due prior to the 1976 appropriation hearings.

MINORITY BIOMEDICAL SUPPORT
(Division of Research Resources)

1. Purpose of program

The Minority Biomedical Support (MBS) Program was initiated in 1972 at the encouragement of the Congress. Initially the program was funded under the auspices of the general research support program and is shown separately for the first time in this presentation. The MBS Program objectives are to (a) increase ethnic minority participation in biomedical research by adding to the pool of minority scientists, (b) strengthen biomedical research capabilities of minority institutions, and (c) use the talents of minority biomedical investigators. The MBS Program constitutes the major focus and effort of the NIH to involve minority institution scientists and students in biomedical research.

The MBS Program is unique and is not modeled after any other program within NIH. Since it started, the MBS Program has been improved and modified. Institutions now eligible include two-year colleges, colleges and universities having a large number of ethnic minority students in addition to ethnic minority colleges, universities, and health professional schools.

2. Funds

1972 obligations	$ 2,000,000
1973 obligations	5,000,000
1974 obligations	8,048,000 1/
1975 estimates	7,165,000
1976 estimates	7,165,000

1/ Includes $1,000,000 1973 released funds

3. Present state of development

An estimated 71 grants supporting 75 minority institutions will be awarded in 1975. Grantees include 55 schools with a predominance of Blacks, 15 schools with a predominance of Spanish-speaking, 3 schools with a large number of American Indians and 2 schools with a large number of Hawaiian/Polynesian. There are 342 faculty and 979 students who currently receive support from the MBS Program.

4. Plans for the future

With the total funds requested for 1976, continued support will be provided to an estimated 67 grants for institutional research programs for involvement of minority scientists in biomedical research and exposure of minority students to the challenges and opportunities in biomedicine.

INTERNATIONAL CENTERS FOR MEDICAL RESEARCH AND TRAINING
(National Institute of Allergy and Infectious Diseases)

1. Purpose of program

Research grants are awarded to American universities to enable these universities to establish centers within both their own organizations, and in affiliate centers within foreign institutions to broaden collaborative research and research training in the biomedical fields to take advantage of unique biomedical problems in foreign countries which are of vital concern to the USA.

2. Funds

In 1961, these grants were administered by the National Institute of Allergy and Infectious Diseases and supported by six of the Institutes plus the Division of General Medical Sciences. This same situation existed in 1962 except for the absorption by Allergy of the support of Heart and Arthritis Institutes. In 1963, the activity was administered by the Office of International Research, OIR, part of the Office of the Director, NIH. In 1964, OIR was incorporated into the GRS appropriation (which no longer exists). In 1969 this activity was transferred to the NIAID and is currently the responsibility of the National Institute of Allergy and Infectious Disesases.

1967 obligations	$ 2,360,000
1968 obligations	2,314,000
1969 obligations	2,300,000
1970 obligations	2,070,000
1971 obligations	2,285,000
1972 obligations	2,399,000
1973 obligations	2,399,000
1974 obligations	2,399,000
1975 estimates	1,799,000
1976 estimates	1,799,000

3. Present stage of development

The initial phase of the program devoted to the administratively complex task of developing foreign research resources in collaboration with selected foreign universities and research institutions has been completed in each of the centers. All centers are now actively engaged in specific research projects.

A substantial portion of current research is focused upon the demography, epidemiology, and ecology of disease states which are of concern to the United States and the host nation. A multidisciplinary approach is being developed within the several centers to study more effectively the complex biomedical problems which prevail at the foreign sites. As a consequence, professional staffs are being developed and trained to investigate, through a selective amalgamation of basic science, clinical and public health research methods, not only tropical diseases, but a wide variety of other disease states which exist in these countries. Accordingly, the scientific programs in each center will progressively encompass a wide spectrum of factors which directly or indirectly influence disease in the United States and abroad.

These programs include studies of environmental factors which may be related to the development and persistence of acute and chronic diseases. The presence of distinct ethnic and demographic groups in foreign areas permit studies in depth of physical and biomedical factors which may be involved in racial susceptibility to disease.

In addition to the research in progress and being planned, each university has an effective training program for U. S. citizens at both the domestic and overseas sites. During 1971 the program was broadened to offer scientific opportunities for investigators from all U. S. medical schools and schools of public health.

The cooperating institutions of the four International Centers now in operation are as follows:

U. S. University	Foreign Cooperating Institutions
Johns Hopkins University----------	All India Institute of Hygiene and Calcutta School of Tropical Medicine, Calcutta, India
University of California----------	Institute of Medical Research, Kuala Lumpur, Federation of Malaysia
Tulane University----------	Universidad del Valle, Cali, Colombia
University of Maryland----------	Federal University of Bahia, Salvador, Brazil

4. Plans for the future

The 1976 President's budget will provide for the continuation of the existing four centers.

GENERAL CLINICAL RESEARCH PROGRAM
(Division of Research Resources)

1. Purpose of program

The Clinical Research program provides the Nation's leading clinical investigators with the specialized resources and facilities necessary to close the gaps in medical knowledge and to translate the latest laboratory discoveries into improved treatment and care for patients.

Patient oriented investigations within the General Clinical Research Centers (GCRCs) cover the entire spectrum of medical research such as cancer therapy, transplantation, obesity, population control, human growth and metabolism, heart disease, high blood pressure, and mental retardation. In these GCRCs, the latest conceptual and technical advances from basic science and animal

research are developed into refined tools to better understand and treat human diseases. Although much medical research can be conducted on laboratory animals, eventually it must progress to the clinical level, where studies are conducted on human subjects. Human subjects also are essential for studying those diseases and biological processes which are not duplicated in other living creatures.

Nationally, approximately two-thirds of all research hospital beds supported by NIH and used for research on human subjects, are funded by this program.

The GCRCs supported through this program are physically discrete research units located in university affiliated hospitals. Traditionally, support is provided for a fixed number of beds staffed by specially trained nursing, dietary, and laboratory personnel and directed by a physician.

2. Funds

1967 obligations	$ 28,463,000
1968 obligations	30,443,000
1969 obligations	35,004,000
1970 obligations	35,004,000
1971 obligations	38,004,000
1972 obligations	42,181,000
1973 obligations	41,300,000
1974 obligations	42,320,000[1/]
1975 estimates	41,308,000
1976 estimates	41,601,000

3. Present state of development

During 1969 awards had been made to 93 General Clinical Research Centers. During 1970, because of increasing hospital costs, 13 centers were notified of phase out. In 1971, 81 GCRCs were funded; in 1972, 84 GCRCs received support; in 1973, 83 were supported; in 1974, 82 received continuing support and one new center was established. In 1975, 84 GCRCs will receive support.

4. Plans for the future

The 1976 President's budget will provide continued support for an estimated 74 General Clinical Research Center Grants, including research on ambulatory patients.

BIOTECHNOLOGY RESOURCES
(Division of Research Resources)

1. Purpose of program

The Biotechnology Resources Program provides biomedical scientists access to highly specialized instruments, and methodologies, as well as staff expert in their use. The program permits and promotes maximum exploitation of new,

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[1/] Includes $807,000 of 1973 released funds.

advanced technologies. Development of new knowledge through health research is subject to many restrictions. The first of these involves technological limitation. Critical research questions can be asked that either cannot be answered with existing technological capability, or require effort of such magnitude and duration that their solution is not attempted. In other cases, existing technology lacks precision, and conclusions drawn may be tenuous. The reduction of these restrictions is the goal of the Biotechnology Research Program. This Program establishes a rewarding interplay between biology and medicine on the one hand, and the physical sciences, mathematics, and engineering on the other by emphasizing the use of digital computation, mass spectrometry, nuclear magnetic resonance spectrometry, and electron microscopy.

The evolution of the Biotechnology Research Program has produced an array of diverse resources, all designed to meet one or more specific technological needs of biomedical scientists. As new, advanced technological tools become relevant to health research, efforts are established to make these tools available to the biomedical community. Because most of the new technologies are more sophisticated and costly than their predecessors, the emerging resources are more complex and they require a more highly skilled and specialized technical staff to maintain and operate them, and to develop applications relevant to health problems. Now that almost all of these resources have been specialized to specific research needs, more meaningful contributions can be made to the biomedical community.

The demand for these costly specialized resources has increased. Support has been shifted from resources which served scientists exclusively in their host institutions, to those which serve scientists throughout the Nation. Establishing nationally shared resources is an economical, scientific and rational way to promote and sustain the broad availability of sophisticated research tools required by modern biomedical research. Now scientists from both small and large institutions are able to use these costly specialized resources and as a result of their increased participation have helped to maximize the potential use of each resource. This has helped us to get more research from each resource and make our resource dollars produce more.

2. Funds

1967 obligations	$ 10,850,000
1968 obligations	10,529,000
1969 obligations	10,494,000
1970 obligations	9,867,000
1971 obligations	9,739,000
1972 obligations	10,924,000
1973 obligations	10,500,000
1974 obligations	12,551,000[1/]
1975 estimates	10,508,000
1976 estimates	10,508,000

3. Present stage of development

The program in 1975 provided support for 17 biomedical computer resources, 18 biomolecular characterization resource grants, 7 biomedical image resource grants and 5 biomedical engineering and other. The 1975 funds will provide support for 39 biotechnology research resources.

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1. Includes $364,000 of 1973 released funds.

4. Plans for the future

The 1976 President's budget will provide for the continued funding of 39 biotechnology research resources.

LABORATORY ANIMAL SCIENCES AND PRIMATE RESEARCH
(Division of Research Resources)

1. Purpose of program

The Laboratory Animal Sciences and Primate Research Program assists institutions by providing animal resources for biomedical research and special research environments for scientists to conduct biomedical and behavioral research using nonhuman primates and other animals. The program also provides training grants and fellowship support in laboratory animal science and medicine to assure a continuous supply of research support personnel.

The general objective of this program is to assist institutions by providing the animal resources so vital to biomedical research. The major dependence of health research on the use of animals emphasizes the need for quality animals to be available to a large number of research investigators under conditions which minimize costs and procurement time. The Laboratory Animal Sciences Program is meeting this need through grant support with the specific objectives of: (a) developing and maintaining laboratories for the diagnosis and investigation of naturally occurring diseases of laboratory animals; (b) providing new knowledge regarding laboratory animal diseases and optimal husbandry of laboratory animals; (c) defining and elucidating new animal biological models; (d) developing, maintaining, and increasing colonies of special research animals such as primates; (e) gathering and disseminating information regarding laboratory animals; (f) assisting institutions to improve their animal facilities and resources and to meet the requirements of the Animal Welfare Act of 1970 (P.L. 91-579) and HEW policies on the care and treatment of laboratory animals; (g) helping increase the number of primates available for research scientists through programs of domestic breeding of primates.

Primate Research:

The closest biological species to man are subhuman primates, and therefore, they are the first choice for many studies of human health and disease; often, they are the only suitable species. Subhuman primates are difficult to breed, expensive to buy, and expensive to maintain. (The price of a juvenile conditioned Rhesus monkey is $150 and costs $1 a day to maintain.) Specimens from the wild carry both apparent and unsuspected monkey diseases and also are susceptible to devastation by human diseases because they lack natural or acquired immunity.

The goals of Primate Research Centers Program include: (a) developing primatology science to deal better with problems of care, disease prevention, diagnosis and treatment, and breeding; (b) providing an environment for research in primates that could not be duplicated elsewhere without difficulty; (c) developing primate models of human diseases and conditions; (d) offering training and expertise in primatology to allow multidisciplinary research; (e) reducing primate research costs by helping investigators to avoid costly mistakes in selection and care of primates, and in the design and conduct of experiments with these species.

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The Primate Research Centers portion of the Program supports seven Primate Centers which provide unique research environments where multidisciplinary biomedical research in many important areas is being conducted. These Centers are providing national and international leadership in the field of medical primatology, and significant research contributions are made each year in the areas of infectious diseases, cardiovascular diseases, degenerative diseases, reproductive biology, and neural and behavioral disorders.

2. Funds

1967 obligations	$ 12,100,000
1968 obligations	15,600,000
1969 obligations	15,068,000
1970 obligations	14,224,000
1971 obligations	14,974,000
1972 obligations	17,337,000
1973 obligations	16,547,000
1974 obligations	17,793,000[1/]
1975 estimates	15,734,000
1976 estimates	15,014,000

3. Present stage of development

The program provided for the support of 79 animal resources and 7 primate centers in 1973. In 1974 it supported 91 laboratory animal science projects and 7 primate centers. In 1975 it will support 67 animal science projects and 7 primate centers. Approximately 9 individual and institutional fellowships will be awarded in 1975.

4. Plans for the future

The 1976 President's budget will support approximately 67 animal resources and 7 primate centers. A total of 8 individual and institutional fellowships will be supported.

CHEMICAL/BIOLOGICAL INFORMATION-HANDLING
(Division of Research Resources)

1. Purpose of program

The Chemical/Biological Information-Handling (CBIH) Program develops and evaluates new computer tools for drug research. The heart of this program is the PROPHET system, a unique computer resource that is shared by a carefully selected community of scientists distributed throughout the country. These scientists are seeking to understand how drugs work. Their ultimate goal is to be able to predict in detail how a new drug or other chemical substance will affect experimental animals and human patients. Such capabilities would do much to reduce the costs of new drug development and to avoid unwanted side effects.

The PROPHET system helps it users by allowing them to deal with larger amounts of data and more complicated types of data than is manually possible. PROPHET also enables scientists who are widely separated geographically to share data and programs directly with one another through the computer and thereby engage in new forms of collaborative research. PROPHET users are

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1/ Includes $843,000 1973 released funds.

able to conduct experiments that are impossible or impractical without the aid of such a specialized computer. This is the first and only time that a community of geographically dispersed drug investigators has shared a research tool of such scope and power.

There are nine PROPHET user groups at present. They are located in Boston, Massachusetts; New York, New York; Buffalo, New York (two user groups); Pittsburgh, Pennsylvania; New Haven, Connecticut; Evanston, Illinois; Seattle, Washington; and Bethesda, Maryland. Steady growth in the number of users is expected to continue. Moreover, new features are continually being added as a result of the users' experiences and suggestions.

Examples of the research objectives of PROPHET users are:

(1) predicting the actions of drugs on the central nervous system through analyses of their shapes and electronic properties;

(2) analyzing the structure of antibodies in order to understand the chemical and genetic mechanism underlying immunity;

(3) studying the three-dimensional shapes of cancer-relevant steroids and relating these structural features to the observed biological activity of these drugs;

(4) studying how the body handles alcohol and other drugs of abuse, and

(5) exploring the uses of computer methods in managing research records of human patients in the clinical pharmacology area.

2. Funds

1974 obligations	$1,273,000[1]/
1975 estimates	1,000,000
1976 estimates	1,000,000

3. Present stage of development

The CBIH Program has (a) enlarged the community of PROPHET users, (b) has made PROPHLT more effective and efficient, and (c) has conducted novel experiments in computer-mediated scientific communication in the drug research area. Also, the PROPHET users began sharing in the continuing costs of operating the service. Significant advances were made towards understanding the molecular basis of the action of cancer-relevant steroids and predicting the effects of drugs upon the brain using information about their three dimensional shapes and electronic properties.

4. Plans for the future

The CBIH Program will continue, through the PROPHET system, to demonstrate where and how computer tools can aid drug research. Special emphasis will be placed on evaluating techniques for studying molecular models and for mimicking drug distribution and metabolism within the body. Among the scientific problems to be investigated are the chemical and genetic bases of immunity and the mechanism by which small polypeptide molecules such as angiotensin II affect blood pressure.

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1. Identified in the budget as a separate program in 1974.

HEART COOPERATIVE DRUG STUDY
(National Heart and Lung Institute)

1. Purpose of program

This program was designed and organized as a large scale national cooperative study to determine whether one or more of the lipid lowering drugs being tested would reduce by 25 percent or more the five-year mortality rate among treated coronary heart disease patients. The hypothesis was that the blood lipids which may have contributed to a first heart attack may to the same extent increase the threat of recurrent heart attacks or other cardiovascular complications among survivors.

Accordingly, the project evaluated five lipid-lowering regimens: estrogens, at two dosage levels; dextrothyroxine, an analog of one of the thyroid hormones; clofibrate; and nicotinic acid. Estrogen is a cholesterol-lowering agent. Clofibrate, dextrothyroxine, and nicotinic acid reduce both cholesterol and triglycerides. The results of the study are directed toward the 1,700,000 Americans afflicted with myocardial infarction.

2. Funds

1967 obligations	$ 3,433,000
1968 obligations	3,820,000
1969 obligations	3,812,000
1970 obligations	3,967,000
1971 obligations	4,579,000
1972 obligations	3,514,000
1973 obligations	4,495,000
1974 obligations	4,897,000
1975 estimates	760,000
1976 estimates	800,000

3. Present stage of development

This study was conducted on 8,341 men aged 30 to 64 who had one or more heart attacks prior to entry into the study. Three treatment regimens were dropped during the course of the study when it became apparent that they were of no positive value. The high-estrogen regimen was discontinued in 1970 because: (a) it was not improving survival rates, and (b) patients on this regimen were suffering more nonfatal cardiovascular events (specifically, nonfatal heart attacks, pulmonary embolism, thrombophlebitis) than were the patients in the control group. Dextrothyroxine was dropped in late 1971 because of decreased survival rates, particularly among higher risk patients. The low estrogen regimen was dropped in 1973 largely because of evidence that it increased the risk of thromboembolism without any compensatory improvement in survival rates. The other two regimens--clofibrate and nicotinic acid--were continued throughout the study and showed no significant benefit in improving survival when compared with the placebo group's experience.

In terms of improved patient survival or reduction in risk from cardiovascular deaths, the benefits of drug therapy were negative. However, had this trial not been conducted, then hundreds, indeed thousands, of patients would continue to be treated in good faith by conscientious physicians with drugs of little benefit. Despite these negative findings, the Coronary Drug Project has demonstrated that data of high precision and reliability can be obtained through large-scale cooperative ventures involving many institutions and investigators following a common protocol. In addition to the findings with respect to the drugs evaluated, the project gained a very large body of

valuable data on the natural history of acute heart attack. The results have been communicated to the biomedical community.

4. Plans for the future

There will be continued analysis and interpretation of the data.

NATIONAL RESEARCH AND DEMONSTRATION CENTERS
(National Heart and Lung Institute)

1. Purpose of program

Public Law 92-423 authorizes that the Director of the National Heart and Lung Institute may provide for the development of National Research and Demonstration Centers: up to 15 Centers for problems related to heart, blood vessel, and blood diseases, and up to 15 Centers for problems related to chronic lung diseases. The purpose of the Centers' program is to facilitate and expedite the translation of basic research findings to practical patient care in local communities across the nation. The Act specifies that this program would encompass "basic and clinical research into, training in, and demonstration of, advanced diagnostic, prevention, and treatment methods for" the respective diseases.

2. Funds

1974 obligations	$ 0
1975 estimates	5,011,000
1976 estimates	5,000,000

3. Present stage of development

A "Program Announcement and Guidelines" for the National Centers, developed with advice from the National Heart and Lung Advisory Council, was released in August 1973. A National Research and Demonstration Center is defined as a national resource attached to a major medical complex and dedicated to working in close collaboration with the Institute to further the goals of the NHLI National Program. Each Center must include programs in fundamental research, clinical research and clinical application, an environment conducive to the training of young scientists, and a demonstration and education program. The Institute reviewed 47 applications for this program in the spring of 1974 for funding in 1975. On the advice of the Council the Institute has activated only three of these Centers--one in heart and vascular diseases, one in lung diseases, and one in blood resources. These Centers are being awarded from regular research grant funds.

4. Plans for the future

The establishment of the initial National Research and Demonstration Centers will provide an important mechanism by which the Institute can assure that the advances gained through research are translated to improved health care in the community.

PHARMACOLOGY-TOXICOLOGY RESEARCH CENTERS
(National Institute of General Medical Sciences)

1. Purpose of program

The purpose of this program is to extend the program efforts of NIGMS in pharmacology and toxicology and to provide funds for the planning, initiation, and support of centers or large scale projects for research in areas of pharmacology and toxicology related to the use of drugs and chemical intoxication. These programs are university based and located in appropriate academic and scientific environments.

2. Funds

1967 obligations	$ 3,358,617
1968 obligations	3,500,000
1969 obligations	3,500,000
1970 obligations	3,325,000
1971 obligations	3,593,000
1972 obligations	5,593,000
1973 obligations	5,593,000
1974 obligations	5,320,000
1975 estimate	6,500,000
1976 estimate	7,315,000

3. Present stage of development

The program was initiated in 1966. Eleven centers are presently being supported. Greater emphasis is being placed on clinical pharmacology and implications of new knowledge as it relates to medical therapy in man.

4. Plans for the future

The President's budget will provide continuing support for the existing centers and fund one or two new centers. Particular emphasis will be placed on further development of the clinical aspects of the program.

DENTAL RESEARCH INSTITUTES (CENTERS)
(National Institute of Dental Research)

1. Purpose of program

The purpose of this program is to provide funds for the development and operation of dental research institutes as centers of excellence in the sciences related to oral health. Organized on an interdisciplinary basis, these institutes support highly competent researchers as they deal with problems specifically related to oral health as well as perform research in the broader biological sciences and engineering and other physiochemical sciences. In addition, the institutes offer an environment unique in breadth and depth of experience for researchers and academicians.

2. Funds

1967 obligations	$ 2,996,000
1968 obligations	3,000,000
1969 obligations	3,000,000
1970 obligations	3,400,000
1971 obligations	4,700,000
1972 obligations	6,500,000

1973 obligations	$ 6,200,000
1974 obligations	7,150,000
1975 estimates	7,200,000
1976 estimates	7,200,000

3. Present stage of development

Currently, five dental research institutes are in operation at the following universities: Alabama, Michigan, North Carolina, Pennsylvania, and Washington.

4. Plans for the future

The President's budget provides continuing support for the five institutes.

ANESTHESIOLOGY AND DIAGNOSTIC RADIOLOGY CENTERS
(National Institute of General Medical Sciences)

1. Purpose of program

The purpose of the anesthesiology and diagnostic radiology centers program is to provide research support for clinical and laboratory investigation related to teaching and patient care in these fields. One aspect of the program will be concerned with research leading to the development and evaluation of new techniques, bringing the fruits of biomedical engineering to the improvement of these specialties which are essential to all branches of health care.

2. Funds

1967 obligations	$ 500,000
1968 obligations	1,000,000
1969 obligations	1,000,000
1970 obligations	950,000
1971 obligations	950,000
1972 obligations	2,066,000
1973 obligations	2,126,000
1974 obligations	2,090,000
1975 estimates	4,000,000
1976 estimates	4,190,000

3. Present stage of development

The program was initiated in 1967. Seven centers have been established to date.

4. Plans for the future

The amounts in the President's budget will provide for the continuing support of the already existing centers. It is anticipated one new center will be funded in 1976.

ENVIRONMENTAL HEALTH SCIENCE CENTERS
National Institute of Environmental Health Sciences

1. Purpose of program

The purpose of the environmental health science centers is to support programs utilizing university-based resources for both research and training programs designed to concentrate research skills and efforts on the complex

and challenging problems in environmental health. The programs embrace numerous facets of environmental health research--clinical and nonclinical activity, routine work and highly original studies, investigations by individuals and by teams, field studies, etc. They also permit experience in environmental health research in a depth that is relatively unavailable elsewhere. University-based center grants may provide for common-use equipment, special laboratories, and salaries for a core group of scientists and administrative personnel. Individual studies are generally supported by funds from other sources.

2. Funds

1967 obligations	$ 2,529,000
1968 obligations	3,000,000
1969 obligations	2,993,000
1970 obligations	2,850,000
1971 obligations	3,050,000
1972 obligations	3,390,000
1973 obligations	3,743,000
1974 obligations	3,885,000
1975 estimates	5,270,000
1976 estimates	5,644,000

3. Present stage of development

In 1974 the Institute supported six university-based centers. One new center will be added in FY 1975.

4. Plans for the future

The President's budget provides for the continuing support of seven centers.

SPECIALIZED RESEARCH CENTERS
(National Institutes of (1) Cancer, (2) Heart and Lung, and (3) Neurology)

1. Purpose of program

The initial design of this program was to provide support for planning and operational grants for specialized centers in the heart disease, cancer and stroke areas. Each of the three Institutes involved makes awards in its own field for analyses of major problems and for the development of programs and resources, i.e., center establishments, to deal in depth with these disease areas. Since 1970 this program has included centers previously listed as "Clinical Research Centers," and thus includes an expanded range of programs - e.g., pulmonary for NHLI and head injury for NINDS, and comprehensive centers for NCI.

2. Funds

	1972 Actual	1973 Actual	1974 Actual	1975 Estimate	1976 Estimate
Heart and Lung	$20,584,000	$22,819,000	$24,445,000	$31,686,000	$ 31,686,000
Cancer	50,203,000	65,100,000	92,452,000	95,699,000	100,699,000
Neurology	5,691,000	5,690,000	5,691,000	5,136,000	5,691,000
Total	76,478,000	93,609,000	122,588,000	132,521,000	138,076,000

3. Present stage of development

In 1971 the National Heart and Lung Institute inaugurated 34 centers in arteriosclerosis, hypertension, thrombosis, and pulmonary disease research. This number was expanded to 42 in 1972 and maintained in 1973 and 1974. It is becoming increasingly evident that these centers are an effective means of mounting part of the Institute's National Program in certain disease categories. These coordinated and focussed research programs, although grant-supported, combine a degree of investigator independence with mission orientation and a close working relationship with the Institute in order to integrate the efforts of one center with the activities of other centers and with those of the Institute. These centers are being awarded from regular research grant funds.

For a number of years NHLI has supported an extramural research program directed specifically at the improved understanding, prevention, and treatment, of heart attack or myocardial infarction. The single largest part of this program has been the Myocardial Infarction Research Units which combine broad programs of clinical research with fundamental laboratory studies and developments in relevant technology and investigative methods. Much of the improvement in the understanding and treatment of heart attack over the past five years has come from these units, which will have completed their program in 1975. As an outgrowth of that program, to build upon it, and broaden the topics of research, the Institute is implementing in 1975 a program of Specialized Centers of Research on Ischemic Heart Disease. Seven such new centers have been funded. The objective of this program is multidisciplinary clinical and fundamental research directed at the reduction of death and disability from all forms of ischemic heart disease, including not only myocardial infarction, but also chronic forms of the disease including angina pectoris, rhythm disturbances and heart failure. The research program is also directed to techniques of rehabilitation and problems of sudden cardiac death.

Currently, the National Cancer Institute supports 74 cancer research centers; 17 of the centers have been classified as comprehensive cancer centers for basic and clinical research, training and demonstration of advanced diagnostic and treatment methods relating to cancer. The remaining centers cover a broad range of clinical and laboratory research. Its goal is a fully developed, geographically balanced network of cancer centers which can interact with each other and with other institutions in their local areas to accelerate the nationwide attack upon cancer.

In 1975, the Neurology Institute supported 55 Specialized Research Centers (SRC's) in a wide variety of special research areas. Of these SRC's, 26 were for stroke (including 11 stroke acute care research units), four were for Parkinsonism, five were for Spinal Cord Injury, and three were for head injury. Other SRC's were for Epilepsy, Multiple Sclerosis, Speech and Hearing, and other Neurological Disorders. These 57 Centers also included Outpatient Units for research in Communicative Disorders.

4. Plans for the future

For the National Heart and Lung Institute in 1976 the noncompeting continuation commitment for the first round of those centers established in 1971 expires. There will be national competition for new or renewed centers to maintain programs in arteriosclerosis, hypertension, thrombosis, and pulmonary disease research at a stable level.

The Cancer Institute plans to continue the support of the cancer centers which are operational in 1975. Planning will continue in many areas throughout the country to determine the feasibility of establishment of cancer centers.

In 1976 Neurology plans to maintain support for the existing centers as well as to encourage universities and other suitable institutions to consider the feasibility of establishing additional centers in areas of special need.

GENETIC RESEARCH CENTERS
(National Institute of General Medical Sciences)

1. Purpose of program

The purpose of the genetic research centers is to conduct both basic and clinical research and to provide training for the various scientists and clinical investigators who will be needed to develop and apply genetic knowledge to prevent and/or alleviate the tragedies of hereditary disease.

2. Funds

1972 obligations	$ 3,000,000
1973 obligations	3,000,000
1974 obligations	5,668,000
1975 estimates	5,000,000
1976 estimates	6,500,000

3. Present stage of development

The program was initiated in 1972. By the end of fiscal year 1973, the number of genetic research centers supported by NIGMS had increased to eight. We are presently supporting ten genetic research centers.

4. Plans for the future

The President's budget will provide continuing support for this program with special emphasis placed on identification of carriers of genetic disease, the genetic mapping of human chromosomes, the development of a bank of human cell culture lines representing important genetic diseases, and research on problems of genetic control in human cells.

MOLECULAR PATHOLOGY RESEARCH CENTERS
(National Institute of General Medical Sciences)

1. Purpose of program

The molecular pathology research centers seek to promote increased collaboration among pathologists, biochemists, biophysicists, electron microscropists, and other basic scientists investigating related subcellular phenomena in more quantitative molecular terms in order to enhance and speed our understanding of the cellular and molecular basis of disease.

2. Funds

1974 obligations	$ 475,000
1975 estimate	500,000
1976 estimate	1,200,000

3. Present stage of development

This program was initiated in 1974 with the first center, at Yale University, for research on cellular membranes, under the leadership of Dr. George Palade, who was awarded the Nobel Prize for his pioneering research on the internal structure of the cell and its organelles. It is anticipated that one new center will be funded in 1975.

4. Plans for the future

The President's budget will provide continuing support for this program with special emphasis on multidisciplinary approaches to the complex problems of the structure and function of the wide variety of cells, their membranes, and subcellular organelles, that make up the organs and tissues of the human body.

TRAUMA AND BURN RESEARCH CENTERS
(National Institute of General Medical Science)

1. Purpose of program

The objective of the NIGMS program in trauma and burn research centers is to reduce the death rate, the amount of suffering, the period of rehabilitation, and the residual disability of victims of all types of injury. Through the support of research centers, program projects, and individual grants, the program encourages fundamental and clinical investigations into the complex problems encountered in the injured patient and burned patient.

2. Funds

1974 obligations	$ 1,900,000
1975 estimates	3,500,000
1976 estimates	5,200,000

3. Present stage of development

Nine trauma and burn research centers are presently being supported. It is estimated that four new centers will be awarded in 1975.

4. Plans for the future

It is estimated that two or three trauma and burn research centers will be awarded in 1976.

BIOMEDICAL ENGINEERING RESEARCH CENTERS
(National Institute of General Medical Sciences)

1. Purpose of program

The purpose of the Biomedical Engineering Research Centers is to exploit further the growing relationship between engineering, biology, and medicine. The efforts of these centers will be variously balanced between research, development, and application, and they are expected to serve as regional foci for special-purpose research or development.

2. Funds

1974 obligations	$ 1,425,000
1975 estimates	1,500,000
1976 estimates	2,200,000

3. Present stage of development

This program was initiated in 1974. We are presently supporting four biomedical engineering research centers.

4. Plans for the future

The President's budget will provide continuing support for this program with special emphasis on the application of engineering control theory to the study of physiological processes, computer-aided clinical decision making, instrumentation research and development, and the use of integrated electronics in medicine. It is anticipated that two new centers will be funded in 1976.

MENTAL RETARDATION CENTERS
(National Institute of Child Health and Human Development)

1. Purpose of program

The Mental Retardation Centers program is designed to conduct broad interdisciplinary research, promptly applying results to prevent mental retardation or help those already afflicted.

2. Funds

1969 obligations	$ 2,000,000
1970 obligations	1,875,000
1971 obligations	3,875,000
1972 obligations	5,608,000
1973 obligations	5,608,000
1974 obligations	5,608,000
1975 estimates	5,608,000
1976 estimates	5,608,000

3. Present stage of development

Currently, twelve mental retardation centers are in operation at the following locations:

University of Chicago, Chicago, Illinois
Children's Hospital, Cincinnati, Ohio
George Peabody College for Teachers, Nashville, Tennessee
University of Colorado Medical Center, Denver, Colorado

University of Washington, Seattle, Washington
University of California at Los Angeles, Los Angeles, California
Albert Einstein College of Medicine, Yeshiva University, New York, New York
University of Kansas, Lawrence, Kansas
Walter E. Fernald State School, Waltham, Massachusetts
Children's Hospital Medical Center, Boston, Massachusetts
University of North Carolina, Chapel Hill, North Carolina
University of Wisconsin, Madison, Wisconsin

4. Plans for the future

The President's budget will provide continuing support for this program.

RESEARCH CAREER PROGRAM
(All Institutes)

1. Purpose of program

This program was designed to increase the number of stable full-time career opportunities for scientists of superior potential and capability in the sciences related to health. The program consists of two types of awards: career awards and career development awards. Career awards support established investigators of high competence for the duration of their careers. No new awards are being made and this program is being phased out as current awards terminate. Career development awards support qualified scientists who have three years or more of relevant postdoctoral research or professional experience and who require additional guided research experience in preparation for careers in independent research. Development awards are normally made for five years.

2. Funds and number of awards

	Number	Amount
1967 obligations	1,159	$ 25,292,000
1968 obligations	1,157	26,840,000
1969 obligations	1,177	27,987,000
1970 obligations	1,129	27,708,000
1971 obligations	1,145	27,858,000
1972 obligations	1,126	26,975,000
1973 obligations	1,060	25,873,000
1974 obligations	896	23,532,000
1975 estimates	865	22,549,000
1976 estimates	790	20,384,000

3. Present stage of development

The program supported 1,060 fellows in 1973. This is the sum of 128 Research Career Awards, and 932 Research Career Development Awards. No new Research Career Awards have been made since 1964. During 1974 896 career fellowships were supported. In 1975 about 876 career fellowships will be funded.

4. Plans for the future

In 1976 the program will provide support for about 790 research career development awards.

REGULAR RESEARCH FELLOWSHIPS/NATIONAL RESEARCH SERVICE AWARDS
(All Institutes)

Note: In this, and the following sections on fellowships and training grants, the tables do not include data for the National Library of Medicine, although it became a component of NIH in 1970.

1. Purpose of program

The purpose of this program is to increase the supply of manpower available for research and teaching by providing qualified individuals with support for training in health related fields. There were three major categories of regular research fellowships: predoctoral, postdoctoral, and special. A new postdoctoral program was added in 1974, the research training program, sometimes referred to as the Weinberger program. On July 12, 1975, P.L. 93-348, the "National Research Act" was signed into law. Under this law prior NIH research training and fellowship authorities were to a large extent withdrawn and the National Research Service Awards authority established as the training program authority. Prior authorities were to continue for all commitments made prior to July 12, 1974.

Predoctoral fellowships provided assistance to individuals who have a bachelor's degree for further training leading to a doctoral degree in science. Postdoctoral fellowships support advanced training for an individual who has already earned a Ph.D., M.D., D.D.S., D.V.M., or equivalent degree. Special fellowships were designed to meet training needs not met by other fellowship programs, by supporting qualified investigators who require additional specialized training. Institutional research service awards would provide blocks of individual research service awards for candidates to be selected by the director of the training program.

2. Funds

	Predoctoral	Postdoctoral	Special	Research* Training	Total
1967 obligations	$8,234,000	$ 7,999,000	$5,920,000	---	$22,153,000
1968 obligations	7,875,000	8,790,000	7,124,000	---	23,789,000
1969 obligations	7,457,000	10,856,000	8,469,000	---	26,782,000
1970 obligations	5,117,000	6,761,000	7,017,000	---	18,895,000
1971 obligations	3,479,000	8,734,000	7,902,000	---	20,115,000
1972 obligations	1,337,000	8,164,000	7,896,000	---	17,397,000
1973 obligations	681,000	5,086,000	4,098,000	---	9,865,000
1974 obligations	172,000	4,347,000	2,986,000	$23,257,000	30,762,000
1975 estimates	75,000	2,736,000	815,000	47,361,000	50,987,000
1976 estimates	60,000	633,000	630,000	50,535,000	51,858,000

3. Number of awards

	Predoctoral	Postdoctoral	Special	Research Training	Total
1967 actual	1,586	1,086	522	---	3,194
1968 actual	1,556	1,058	579	---	3,193
1969 actual	1,508	1,389	684	---	3,581
1970 actual	1,042	824	561	---	2,427
1971 actual	721	1,094	573	---	2,388
1972 actual	303	1,052	575	---	1,930
1973 actual	155	603	294	---	1,052
1974 obligations	40	432	197	1,436	2,105
1975 estimates	6	248	54	3,001	3,309
1976 estimates	5	57	42	2,797	2,901

*Includes Weinberger program and National Research Service Awards.

4. Present stage of development

There is a decrease in the total number of fellowships in this program, beginning in 1970 and continuing through 1973, related to the planned phase out of the predoctoral program. With the inauguration of the postdoctoral research fellowship program in 1974 and the enactment of the National Research Act, future years will show a corresponding decrease in the earlier awards category. Some of the increase in actual numbers in 1974 is the result of restored funds from 1973, some of the increase in both 1974 and 1975 results from the Weinberger program.

5. Plans for the future

The number of fellowships supported in 1976 will decreased by about 400 from the number supported in 1975.

FOGARTY SCHOLARS-IN-RESIDENCE
(John E. Fogarty International Center for Advanced Study in the Health Sciences)

1. Purpose of program

This program is designed to facilitate the discussion, expansion and evolution of ideas between distinguished leaders in science, scholars in other disciplines and other creative individuals. The program selects outstanding scientists and scholars from the international biomedical community, provides for their residence at the Fogarty International Center and has them focus their attention on broad aspects of important issues raised by the findings of modern biomedical research.

2. Funds

1969 obligations	$ 192,000
1970 obligations	167,000
1971 obligations	170,000
1972 obligations	270,000
1973 obligations	269,000
1974 obligations	269,000
1975 estimates	270,000
1976 estimates	270,000

3. Present stage of development

As of January 1975, there have been a total of 41 participants. These distinguished individuals, representing expertise in the broad biomedical field are involved in individual projects, provide inspiration to the intramural scientists with whom they come in contact, and initiate conferences, seminars and workshops.

4. Plans for the future

Funds in the President's budget will provide support at the $270,000 level.

INTERNATIONAL RESEARCH FELLOWSHIPS
(John E. Fogarty International Center for Advanced Study in the Health Sciences)

1. Purpose of program

This program provides awards to promising foreign scientists to support their research efforts while in the laboratories of United States scientists. While these awards contribute to the improvement of foreign research capabilities, the primary objectives of this program are domestic. These objectives are achieved by enabling foreign investigators to share their ideas and background with American colleagues, and by encouraging foreign scientists to participate in research bearing on American health problems. As this research is often continued and extended by the fellow upon return to his home, additional opportunities are created for future collaborative efforts in research endeavors of importance to the United States.

2. Funds and number of awards

	Number	Amount
1967 obligations	155	$1,200,000
1968 obligations	159	1,378,000
1969 obligations	173	1,419,000
1970 obligations	142	1,027,000
1971 obligations	130	1,076,000
1972 obligations	163	1,607,000
1973 obligations	92	777,000
1974 obligations	162	1,884,000
1975 estimates	103	1,314,000
1976 estimates	78	930,000

3. Present stage of development

This program was established in Western Europe in 1958 with 15 countries participating. Plans were made at that time for an orderly increase in the number of participating countries based on research potential and likelihood that returning fellows would use research techniques learned while in the United States. The number of countries participating each year is as follows: 1959 - 30; 1960 - 36; 1961 - 36; 1962 and 1963 - 41; 1964 and 1965 - 42; 1966 through 1968 - 43; 1969 through 1970 - 44; 1971 - 43; 1972 - 43; 1973 - 35; 1974 - 38; 1975 - 33, and 1976 - 30.

4. Plans for the future

In 1976 approximately 78 fellows will be supported.

SENIOR INTERNATIONAL FELLOWSHIPS
(John E. Fogarty International Center for Advanced Study in the Health Sciences)

1. Purpose of program

The Senior International Fellowship Program provides opportunities to outstanding faculty members at mid-career from U. S. schools of medicine, osteopathy, dentistry and public health with demonstrated productive scholarship and recognized stature in their profession to go abroad to study and share their expertise. This program is intended to be a career enhancing educational experience with mutual benefits to all involved.

2. Funds and number of awards

	Number	Amount
1975 estimates	24	$600,000
1976 estimates	32	800,000

3. Present stage of development

This program, announced mid-year of fiscal 1974, has had an enthusiastic response from the U. S. scientific community. Without regard to the very limited time frame within which to qualify for 1975 awards, inquiries have been received from over 400 individuals from 45 states. In addition, at this writing, applications from 25 faculty members representing 21 universities have been received for consideration.

4. Plans for the future

This program will be continued as high quality applications are received.

TRAINING GRANTS

1. Purpose of program

These grants supported training in specified aspects of health, medicine, and allied fields with the major objectives of (a) providing an adequate supply of competent research and teaching manpower, and (b) facilitating within the student bodies of health-related professional schools the development of knowledge about special areas of disease that have particular significance. The training grant fulfills a dual function. Its funds underwrite certain expenses related to the specific training mission, including the provision of stipends to individuals selected for that training, except in (b) above. It also serves to create and maintain an atmosphere essential to the training by providing a focal point for the specific discipline or disease within the training institutions. The following table does not include data for the National Library of Medicine.

2. Funds

1967 obligations	$ 134,403,000
1968 obligations	134,951,000
1969 obligations	141,941,000
1970 obligations	131,110,000
1971 obligations	132,367,000
1972 obligations	139,650,000
1973 obligations	105,542,000
1974 obligations	153,573,000
1975 estimates	82,468,000
1976 estimates	71,788,000

3. Present stage of development

The training programs of most of the NIH Institutes are directed toward the provision of adequate manpower for research in those disease areas for which they have assigned responsibilities. In contrast, the programs of the National Institute of General Medical Sciences are designed to support the fundamental sciences which undergird the disease-oriented interests of the categorical institutes. For this reason, their training programs cover the full range of the basic biomedical sciences.

51-805 O - 75 -- 61

In 1973, 1,736 training grants were supported; in 1974, 1,272 were supported as a result of the phase out of this program initiated in 1973. In 1975 as the phase out continues 1,024 grants will be supported.

4. Plans for the future

Plans call for continued phasing out of this training grant program -- to be completed with the end of commitments made with 1973 funds. An estimated 740 grants will be awarded in 1976.

Both the Weinberger program and the National Research Service Awards allow some fellowship block grants to institutions. These are included in The Regular Research Fellowships tables above, in the column entitled "Research Training."

LIST OF WITNESSES

	Page
Abdellah, F. G.	443
Baier, F. J.	305
Batalden, Dr. P. B.	121
Bersano, P. J.	1, 443
Besteman, K. J.	488
Bloom, J. D.	305
Brown, Dr. B. S.	488, 689
Buckley, J. P.	715
Chafetz, Dr. M. E.	488
Cooper, Dr. Theodore	1, 443
Deering, J. A.	488
Droke, J. C.	443
DuPont, Dr. R. L.	488
Endicott, Dr. K. M.	1, 715
Forbush, Wilford	443
Goody, P. E.	689
Goran, Dr. M. J.	121
Isbister, J. D.	1, 488
Lamont-Havers, Dr. R. W.	1
Leone, J. R.	488
Little, W. H.	121
Mahoney, J. D.	488
Margulies, Dr. Harold	1
Miller, Charles	1, 121, 305, 488, 689, 715
O'Donnell, J. J.	689
Peele, Dr. Roger	689
Perrin, Dr. E. B.	715
Pittman, J. E.	488, 689
Plaut, Dr. T. F. A.	488
Proctor, J. M.	488
Robinson, Dr. L. D.	689
Rosenthal, Dr. G. D.	715
Rorrie, Dr. C. C. Jr.	715
Sencer, Dr. D. J.	1, 305
Simmons, Dr. H. E.	1, 121
Small, Morton	878
Smith, Lee	878
Streicher, Dr. R. E.	121
Trusty, M. K.	488
Van Hoek, Dr. Robert	1, 121
Waldrop, Dr. F. N.	488
Weinman, D. N.	443
Whiteside, Dr. D. F.	715
Williams, T. F.	689

INDEX

A

Page

Alcohol, Drug Abuse, and Mental Health Administration 488–688
Alcohol:
Accomplishments 518
Alcohol abuse and alcoholism 495
Alcohol abuse and heart disease 514
Alcoholism formula grants 510
Community programs 591
Education 591
Funding levels 519
Highway deaths 556
Indian alcoholism projects 509
Industrial alcoholism programs 507
Minority groups in alcohol programs 590
Model insurance benefits package for alcoholism 508, 525
Moderate drinker 513
Occupational alcoholism program 523, 592
Prevention programs 511, 580, 581
Research 496, 497, 581, 582
State formula grants 549, 593
Third party payments 499, 507, 592, 594
Training grants 597
Treatment and prevention of alcoholism 496, 521, 522
Evaluation of treatment techniques 524
Uniform Alcoholism and Intoxication Treatment Act 507
Volunteer organizations 514
Youth use of alcohol 511, 526, 579
Budget reduction 499
Coordination of activities 543
Crime and delinquency 605
Drug abuse 495
Age groups 580
Budget reduction 512
Clinical/biomedical centers 597
Distribution of drugs 516
Drug abuse community programs, reduction in 560
Drug and alcohol susceptibility 596
Drug and alcohol usage combined 578
Education program 600
Federal expenditures on 602
Formula grants 601
Heroin distribution and use 511, 527, 551, 556, 559, 566
Manpower requirements 600
Marihuana 512, 541, 579, 597
Methadone 567
Mexico, narcotic addiction in 558
Prevention programs 580
Research grants, decrease in 595
Technical assistance 601
Third party payments in drug treatment projects 594
Tracking systems 602
Traffic in drugs 559

Page

Alcohol—Continued
Treatment ... 497
Techniques, research in ... 595
Use of drugs, increase in ... 567
Federal expenditures related to alcoholism ... 517
Grade level increases ... 553
Health planning ... 606
Justification of the budget estimate ... 610
Mental health ... 495
Aging and mental health ... 603
Child mental health ... 519, 603
Community mental health centers ... 498, 522, 541, 543, 551, 608
Construction grants ... 502
Funding of ... 543
Minority groups ... 545, 561
Patients in institutions ... 504
Positions for ... 544
Regulations for ... 549
Revenues ... 542
Title IV(a) and VI ... 501, 543
Defining mental health priorities ... 506
Federal role in mental health efforts ... 548
Hospital improvement program ... 606
Intramural research ... 607
Manpower needs ... 503, 546, 607
Minority mental health ... 606
National Institute of Mental Health ... 497
Prevalence of mental illness ... 547
Preventive mental health ... 520
Research projects and funding ... 498, 504, 548, 603, 606
Monitoring research grants ... 609
Schizophrenia ... 604
Staff, cutback in ... 550
Technical assistance efforts ... 609
Training program ... 503, 545, 555, 608
Minority participation in programs ... 561
Noncompeting commitments ... 499
Organization of State programs ... 516
Position allocations ... 552
Regional offices ... 552
Reorganizations ... 553
Rescission of funds ... 550
Statewide service program contracts ... 600
Volunteer organizations, role of ... 514
Youths, prevention programs for ... 596
Assistant Secretary for Health, testimony of ... 1–120
Alcohol, drug abuse, and mental health programs, reduction of ... 14
Ambulatory care facility ... 111
Arthritis and diabetes activities ... 11
Biomedical research ... 10
President's Biomedical Research Panel ... 71
Birth rate ... 4
Budget for fiscal year 1976 for Public Health Service:
Level of ... 15
Source of funds to pick up cutback in ... 82
Cancer research ... 11, 37, 97
Budget reduction ... 110
Commission on Protection of Human Subjects ... 12
Community Mental health centers ... 19, 72, 109
Social rehabilitation service reimbursements to ... 20
Comprehensive grants to States, termination of ... 17, 36
Contributions, non-Federal ... 6
Diabetes research ... 98
Emergency medical services ... 8, 113

Assistant Secretary for Health—Continued Page
Evaluation study 117
Forward plan for health, 5-year 16, 93
Grants, capitation 13, 120
Grants, continuation 18
Health education 100
Health insurance, national 94, 116
Health maintenance organizations 8, 92, 106
Health manpower 115
New policy on 12
Health practice standards, improving of 91
Health professions 13
Heart and Lung Institute findings 10
Improvement of health care 7
Infant mortality rates 3, 21, 118
Malpractice insurance 9, 91, 107, 120
Medicaid definition of 5
Medicare definition of 5
Mortality rates 3
National Center for Health Services Research 8
National Center for Health Statistics and National Center for Health Service, relationship of 109
Natonal Health Planning and Resources Development Act of 1974 14, 119
National Health Service Corps 111
National Health Service scholarships 108, 120
Nursing homes 119
Facilities 23
Population of 4
Quality of 101
Occupational health 95
Predoctoral fellowship phaseout 117
Predoctoral research training at NIH 18
Priorities of research projects 23, 81
Professional standards review organizations 7, 82, 106
Public Health Service budget overview 6
Public Health Service hospitals 112
Rescission of funds 21
Research findings 110
Research projects, study on wasteful 28
Role of state, local governments and private concerns 119
Smoking and health research 38
Source of funds other than Federal for health programs 82, 119
State contributions 83
States' resources to carry health programs 17
Statistical health data, improvement of 9
Suicides 3

C

Center for Disease Control 305–442
Preventive Health Services 305
Accomplishments in infectious disease control 306
Birth defects 384
Common communicable diseases 389
Comprehensive health formula grants 384
Diagnostic reagents 381
Disaster related health problems 389
Gonorrhea 310
Health education 314, 385
Health of workers 308
Immunization 311, 318, 375
Justification of the estimate 391
Laboratory diagnosis 382
Laboratory improvement 313, 359, 366, 379, 383
Lead-based paint poisoning 312, 359, 370, 376, 383

Center for Disease Control—Continued Page
National Institute of Occupational Safety and Health 319
Budget request and allowances 323
Cancers of occupational origin 330
Criteria documents 324, 328
Field studies 325, 331
Hazard evaluation 329, 353
Hazards survey 354
Occupational carcinogenesis 371, 389
Occupational diseases 319, 365
Occupational health research 352
Occupational insult exposures 387
Occupational safety 387
Personnel ceilings, end of year 326
Physical facilities 322
Smallpox eradication 367, 371
Toxic substances 320
Training grants 327
Polio 369
Rat control program 311, 369, 379
Smoking 318
Syphilis 309
Travel expenses 316
Tuberculosis 384
Venereal diseases 311, 366, 375, 385
Training of medicare surveyors 381
Tropical diseases 371

H

Health Resources Administration 715
Allied health professions 722, 774
Authorizing legislation 728
Budget for fiscal year 1976:
Compared with 1975 773
Overview of 721
Capital expenditure reviews 754
Competency of health professionals 762
Comprehensive Health Manpower Training Act of 1971 771
Computer system 751
Cooperative health statistical system 737, 763
Cost of 752
Designating health service areas 739
Development of knowledge 722
Division of Dentistry 748
Family planning reporting system 764
Foreign medical graduates 747
Guidelines for distribution of allotments to States 755
Health problems, coping with 760
Health education, cost of 759
Health facilities construction assistance 725
Health Planning and Resources Development Act, implementation of 765
Health professions 774, 776
Health services research centers 761
Improvement of health care systems 723
Institutional assistance, reduction in 771
Justification of the budget estimates 777
Malpractice claims, reducing of 743
Malpractice insurance 763
Managing the health care delivery system 723
Manpower needs 758, 761
Medical consumer organizations 771
Medical facilities construction 742
Medical manpower supply and demand 732
Minimum data 756
National health insurance 760

Health Resources Administration—Continued — Page
- National health service scholarship program — 759
- Number of Health service agencies — 753
- Nurse Training Act of 1971 — 773
- Nursing — 775
- Office of Health Resources Opportunity — 776
- Operations under continuing resolution — 728
- Personnel of health service agencies — 752
- Planning methods development programs — 755
- Position breakdown — 750
- Prevention — 726
- Program management positions — 747
- Quality systems — 726
- Research — 732
  - Decrease in funding — 756
  - Elimination of health services research — 770
  - Examples of — 735
  - Intramural activities — 733
  - Results of — 757
  - Section of areas for — 734
- Socioeconomic and disadvantaged individuals — 772
- Staffing of health systems agencies — 741
- State health planning and resources development agencies — 753
- Statewide Health Coordinating Council — 755
- Student loans — 742, 770
- Tracking and evaluation — 727
- Training costs — 751
- Transition period budget — 740
- Veterinarian shortage — 759

Health Services Administration — 121–303
- Birth rates — 148
- Coast Guard alcoholism program — 187
- Community health centers — 129, 188
  - Project management — 141
  - Third party reimbursements for — 168
- Comprehensive health grants to States — 127, 142, 181, 191
- Contract medical care — 181
- Cost of medical services — 178
- Crippled children's services — 134
- Emergency medical services — 140, 179
- Family planning — 134, 145, 169, 184
  - Spending levels — 155
- Health maintenance organizations — 136, 156, 179
  - Dual option provision — 188
  - Program support — 142
  - Regulations — 137
  - Rural set-aside for — 173
- Health service projects — 158
- Indian health service budget — 169
- Justification of the estimate — 192
- Marshfield Clinic — 174
- Maternal and child health grants to States — 131, 190
  - Crippled children's services — 187
  - Needs of — 133
  - Projects — 170
  - Reimbursements, third party — 131, 190
  - Training programs — 174
- Migrant health — 135, 171
  - Mobile units for — 136
- National health insurance — 178
- National Health Service Corps — 157, 170, 187
- Nursing homes — 138
  - Impact of professional standards review organizations — 139
- Patient care — 187

Health Services Administration—Continued Page
Pediatric pulmonary centers 143
Professional standards review organizations 139, 158, 168, 174, 179, 189
Program management 141
Public Health Service hospitals 140
Sudden infant death syndrome 144, 188
Travel expenses 165

O

Office of the Assistant Secretary for Health 443–487
Decentralization of Public Health Service programs 456
Grant management policies 459
Health care assurance 448
Health care system 450
Health policy board 462
Health quality assurance 451
International health efforts 466
Justification of the budget estimates 469
Long-term health care 462, 463
National health insurance 445, 456
Nursing homes:
Inspection of 460
Number and types of 449
Regulations 461
Training of professionals 452
President's Council on Physical Fitness and Sports 449
Professional Standards Review Office 451, 459, 468
Program direction and support services 448
Regional health administrator's work program 458
Regional management 447
Regional offices 464
Central staff 453
Utilization review regulations 452

R

Retirement Pay and Medical Benefits for Commissioner Officers 878
Bonus pay and medical care cost 881
Justification of the budget estimates 882
Obligations 879
Transfer of Public Health Service hospitals to communities 880

S

St. Elizabeths Hospital 689–714
Accreditation 692
Community mental health services 697
Financing 695
Improvements in treatment 698
Justification of the budget estimates 701
Narcotic addiction program 699
Operating deficit 695
Referral system 696
Training 698
Transfer to District of Columbia 696
Unitization 699
Special reports 894–966
ADAMHA research and training grant programs 937
Black lung disease 895
Immunization 901
Lead-based paint poisoning 902
Pediatric pulmonary centers 908
Sudden infant death syndrome 912
Venereal diseases 919

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