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# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1977

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## HEARINGS

BEFORE A

## SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

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

DANIEL J. FLOOD, Pennsylvania, *Chairman*

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HENRY A. NEIL, Jr., FREDERICK P. PFLUGER, ROBERT L. KNISELY, NICHOLAS G. CAVAROCCHI, and GEMMA M. WEIBLINGER, *Subcommittee Staff*

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## PART 3

## DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE:

## HEALTH ACTIVITIES
## (Excluding National Institutes of Health)

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Printed for the use of the Committee on Appropriations

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U.S. GOVERNMENT PRINTING OFFICE
68-650 O WASHINGTON : 1976

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# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR FISCAL YEAR 1977

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FRIDAY, FEBRUARY 20, 1976.

## DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

### WITNESSES

DR. THEODORE COOPER, ASSISTANT SECRETARY FOR HEALTH
DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL
DR. JOHN F. FINKLEA, DIRECTOR, NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH
DR. DONALD S. FREDRIKSON, DIRECTOR, NATIONAL INSTITUTES OF HEALTH
DR. ROBERT VAN HOEK, ACTING ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION
JAMES D. ISBISTER, ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
DR. KENNETH M. ENDICOTT, ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER
PETER J. BERSANO, DIRECTOR, OFFICE OF RESOURCE MANAGEMENT, PUBLIC HEALTH SERVICE

Mr. FLOOD. The subcommittee will come to order.

We have the Department of Health, Education, and Welfare. We are pleased to have Dr. Theodore Cooper, the Assistant Secretary for Health.

Who do you have with you that you want us to know?

Dr. COOPER. We have a very distinguished panel, Mr. Chairman, and members of the committee, and I would like to go around from left to right.

Dr. Donald Fredrickson, the Director of the National Institutes of Health; Dr. Kenneth Endicott, the Administrator of the Health Resources Administration; Mr. James Isbister, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Dr. Robert van Hoek, the Acting Administrator of the Health Services Administration.

Then to my right, Mr. Peter Bersano, the Director of our Office of Resource Management in the Public Health Service, and to his right Dr. David J. Sencer, Director of the Center for Disease Control and at the far right, our distinguished colleague from the Secretary's Office, Mr. Charles Miller.

Mr. FLOOD. Well, we have your biographical sketch of you, Dr. Cooper, and, of course, we will place that in the record at this point.

[The information follows:]

BIOGRAPHICAL SKETCH

Name: Theodore Cooper, M.D.
Position: Assistant Secretary for Health.
Birthplace and date: Trenton, N.J., December 28, 1928.
Education: B.S., Georgetown University, 1949; M.D., St. Louis University School of Medicine, 1954; and Ph. D., St. Louis University, 1956.
Experience: May 1975, present Assistant Secretary for Health, Department of Health, Education, and Welfare; 1974 to May 1975, 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 Universtiy; 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 Society for Clinical Investigation, 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, Phi Delta Epsilon.
Honor and awards: Distinguished Service Award, American College of Cardiology, 1974 16th Honorary Lecture Award, Albany Medical College, Albany, 1972. John J. Hammond Lecture, St. John's Medical Center, St. Louis, 1972. Arthur M. Master Lecture, Mount Sinai School of Medicine, N.Y., 1972. Gold Heart Award of the American Hearth Association. 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. Research Career Development Award, USPHS, 1962–1966. Who's Who in American Colleges and Universities, 1956. Bordon Award, St. Louis University, 1954.

Dr. COOPER. Yes, sir.

Mr. FLOOD. I see you have a prepared statement, Dr. Cooper. How do you want to handle this?

Dr. COOPER. Well, I would like to proceed with reading the statement, if I may, Mr. Chairman.

Mr. FLOOD. Very well, as you wish.

Dr. COOPER. Mr. Chairman and members of the committee: I am here today to present the fiscal year 1977 budget request for the Public Health Service and to outline some of the goals and objectives we hope to achieve within the framework of this budget. Before discussing specific budget proposals, however, I would like to place the requests you have before you in perspective by describing the state of the Nation's health.

HEALTH STATUS

The health of the American people is, without a doubt, our most valuable national resource. Without good health, our citizens can do little to achieve other goals—for themselves, their children, or for the Nation as a whole. We have made great strides in recent years in im-

proving our health status. Yet this progress is sometimes obscured when we view it on a year-to-year basis only. Earlier this month, we transmitted to the Congress a 3-volume, 600-page study entitled, "Health, United States, 1975." The report, the first in an annual series, details the tremendous progress we have made in improving the health of the Nation, yet outlines the enormous challenge that still remains.

Infant mortality, often regarded as a major indicator of a nation's well-being, declined from 29.2 deaths per 1,000 live births in 1950 to an estimated 16.5 deaths in 1974. Despite the achievement of reducing infant mortality in the United States by 40 percent since 1950, we as a nation still rank 15th in this statistic. In addition, the infant death rate for nonwhites continues to run considerably higher than for whites.

Early prenatal care is essential for detecting conditions which may lead to complications of pregnancy and delivery as well as fostering conditions for healthy natal development. While about 70 percent of all pregnant women start prenatal care during the first 3 months of pregnancy, only 52 percent of nonwhite women undertake such care at that time. If we are to continue to reduce our infant mortality rate, it will be necessary to focus even more attention on the need for prenatal care.

Life expectancy, another key indicator of the Nation's health, is now 76.7 years for white women and 68.9 years for white men, an increase of 2.1 years and 1.2 years, respectively, in the past decade. But life expectancy for nonwhites continues to lag, with a lifespan of about 71.3 years for women and 62.9 years for men. Despite the decline in death rates from heart conditions in recent years, heart disease remains the leading cause of death in this country. Heart conditions are also the leading cause of inpatient hospitalization and cause more long-term limitation of activity than any other condition.

During the past 25 years, death rates from some other major diseases have declined. The rates for strokes, arteriosclerosis, and kidney disease have all shown marked reductions. However, a notable exception has been cancer, which ranks second in causes of death and has increased from 269 deaths per 100,000 persons in 1950 to 292 in 1973. Other exceptions to the general decline in mortality rates are increases in rates for the fifth leading cause of death of the middle aged, cirrhosis of the liver, and for the ninth cause, respiratory diseases. Death rates for cirrhosis of the liver, which is associated with alcoholism, and respiratory diseases, which are aggravated by smoking and air pollution, still cause only a small fraction of the number of deaths caused by heart disease.

While the leading causes of death are indicative of major health problems and of losses to the economy because of death during the working years, mortality data alone fail to describe the full impact of disease and disability. Interview data reveal that of the 43 million people who are 45 to 64 years old, 1.5 million are limited in their activities because of heart problems. Approximately 1.3 million are limited by arthritis, 620,000 by impairments of the lower limbs or hips, 420,000 by hypertension and 400,000 by diabetes.

And I would say parenthetically here, Mr. Chairman, that I am emphasizing this is only a selected age group. Problems like diabetes,

which the recent report of the National Commission has outlined, point out that millions of people are afflicted by this condition. Diseases such as diabetes are contributing to more and more deaths in the cardiovascular area. There are great needs in this area.

I previously commented in some detail before this committee on the problem of the millions of people of all age groups who are victims and potential victims of hypertension and its complications. In total, there are 8 million adults in their middle years who report some degree of chronic limitation of activity.

One disturbing statistic is that a preventable condition, venereal disease, is reaching epidemic levels. When undetected cases and underreporting are considered, it is estimated that about 2.7 million cases of gonorrhea occur each year. There are about 81,000 new cases of infectious syphilis each year and about 450,000 persons are in need of treatment for syphilis at the present time.

Although there are still wide differences in health status between poor and not-so-poor, it is evident that the gap in opportunity for health care has been reduced. In 1974 17 percent of the poor had not seen a physician within 2 years, in contrast with 23 percent in 1964. For those who were not poor, the respective proportions were 13 and 18 percent.

The fact that the poor often have higher rates of utilization of physician services than the nonpoor reflects both a greater need for health care in this group and a catching up of a deficit which has accumulated in earlier years, which only underscores, in my view, that health status is not only a reflection of the performance of the technical aspects of the health care system but a reflection of the social, economic, and cultural factors which contribute to health status in this country.

A dramatic change that has been occurring in our population has been the sharp rise in the number of people over 65. Between 1940 and 1970 the Nation's elderly population has doubled to 20.2 million. As a consequence, the incidence of chronic arthritis, diabetes, and other diseases linked with aging has also increased. As needs for care become overwhelming and there is no one in the household to provide this care, some solution must be found. One possibility is home health care; the other is long-term institutionalization.

About 1 million people, 5 percent of our elderly population, reside in nursing homes and because of longer survival, 72 percent of these are women. Nearly all of the residents have multiple chronic conditions, averaging three per person.

Health care has been taking an increasing share of the Nation's total production of goods and services. In 1975 national health expenditures totaled approximately $118.5 billion or 8.3 percent of the Gross National Product. This represents a per capita expenditure of $547. In 1950 these expenditures were $12 billion, representing 4.6 percent of the GNP and a per capita cost of $78. The change is due primarily to inflation and to increased use of services, including new and costly techniques of care. Sources payment of these health care costs have shifted markedly. In 1950 over two-thirds of personal health care costs were paid directly by the patient; in 1974 the patient's direct share was one-third of the total. This shift is due to

the growth in private health insurance coverage of the population and to the introduction of public programs such as medicare.

These statistics show the progress that has been made over the years in preventing disease and delaying death as well as revealing those areas where improvement is required. While we can continue to look forward to improved medical care, it is becoming clear that a substantial improvement in health status could be achieved by individuals changing the way they live. Most accidental deaths and disabilities are preventable. So is the aggravation of health conditions due to the excessive use of alcohol and tobacco and lack of exercise and proper diet. Almost half of the adult population 22 years of age and older does not engage in routine physical exercise. While the proportion of adult males who smoke cigarettes dropped significantly between 1955 and 1970, from 54 percent to 43 percent, the proportion of female cigarette smokers increased, from 27 percent to 31 percent during the same period. Frequent heavy drinking of alcohol is highly related to mortality; for example, males who drink heavily at least four times a week have death rates four times higher than do other drinkers. These trends and factors, which are tied to our lifestyle and the relative affluence of our society, can all be adjusted by individual action. Simply stated, the health of the people of our country can be improved if individuals would cut down on drinking and smoking, would exercise more, and eat a proper diet.

## PUBLIC HEALTH SERVICE OVERVIEW

We seek to improve the health of the American people through four basic approaches within the Public Health Service program. Prevention of disease is in the long run the most effective. This we are achieving by reducing the spread of communicable diseases, by improving the quality of our environment, by programs aimed at health education, and by regulation of drugs, devices, and clinical laboratories. It is essential that all citizens have access to appropriate health care, and this we seek to achieve through programs aimed at providing health services to the medically underserved as well as through the financial support provided by medicare and medicaid. Containment of health care costs is essential if we are to keep them within reasonable bounds. Through our PSRO program, which requires reviews of hospital admissions, through better health planning and through research into more efficient ways to deliver health care services, we are initiating major steps to control health costs. Continued investment in medical research develops the knowledge that is needed to form the basis for changes in prevention treatment, and control of disease. We are increasing our medical knowledge through our biomedical research programs at NIH and behavioral studies in ADAMHA.

As you know, there are two major legislative proposals to be submitted by the President in the coming months which will have a significant bearing upon the budget request for fiscal year 1977. One is a proposal to consolidate 16 Federal health programs, including medicaid, into a single $10 billion block grant to the States called the Federal Assistance to Health Care Act.

The other is to seek approval to transfer to community use or close the eight Public Health Service hospitals. If the Congress approves this proposal, the primary beneficiaries of these hospitals will continue to receive care from the existing PHS clinics and through contractual arrangements with community medical facilities. The budget being presented to you now, however, requests funds for these programs under existing legislative authorities to assure continuity of activities pending congressional action. Progress toward achieving these goals will be made in 1977 within the budget that we are requesting.

The total budget request for the Public Health Service is $4.38 billion for 1977.

That does not include the Food and Drug Administration and the Indian Health Service which are considered by other committees.

This request, while recognizing contraints, reflects priority needs designed to prevent illness, assure access to appropriate care, contain health costs, and carry on health research. I would now like to review briefly the major items in this request.

PREVENTION

For the Center for Disease Control we are continuing to place a high priority on the activities of the National Institute of Occupational Safety and Health (NIOSH) and on our laboratory improvement effort. NIOSH will continue to carry out research on hazardous substances and harmful physical agents. The budget for NIOSH will allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiological investigations in 40 high risk industries. The budget will enable DHEW to recommend to the Department of Labor during each of the next 2 years criteria on 24 hazardous substances that impinge on the health of 1.7 million in the workplace. The $4.5 million increase for laboratory improvement will permit a 50-percent increase in efforts to improve the ability of clinical laboratories to perform reliable and accurate tests. This will result in a savings of both dollars and unnecessary hospitalization. We will also continue our emphasis on health education so that individuals can make better informed health decisions and take action to improve their health status.

ASSURING ACCESS TO CARE

Improvements in access to appropriate care will be made through our efforts to build a rational resource allocation system. An important part of this effort to build capacity through appropriate resource allocation is the health planning program for which we are requesting $90 million in fiscal year 1977. This request will permit the orderly development of a nationwide network of 211 conditionally operational health systems agencies and 56 State or territorial health agencies.

The need to begin resolving the geographic and specialty distribution problems of qualified health professionals is another vital ingredient in assuring access to appropriate care. Our budget request of $319 million for health manpower programs is allocated in accordance

with the administration's Health Professions Education Amendments of 1975 recently submitted to the Congress.

A major component of assuring access to care is our effort to build capacity directly in medically underserved areas. Within the $319 million noted, we have requested $35 million for the health service scholarship program which will support 4,650 students who agree to serve in these shortage areas. A significant increase is also being requested for the National Health Service Corps, whose mission it is to actually place health professionals in medically underserved areas. For fiscal year 1977, $24.5 million is being requested to support 676 assignees at 330 sites.

While discussing the issue of access to proper health care, it is appropriate to mention developments regarding St. Elizabeths Hospital (SEH). The accreditation for St. Elizabeths was withdrawn because of nonconformity with fire and other safety regulations, an insufficient number of qualified personnel and the lack of adequate physical resources to meet patient needs. The President's supplemental request for 1976 and the 1977 request includes resources to provide additional staff, to correct fire and safety hazards, and to develop plans for additional space to relieve overcrowding. While the budget request assumes Federal control of the hospital for the present, we are currently working with the Government of the District of Columbia to arrive at mutually agreeable terms and a date for transfer of the hospital to the District. When agreement is reached, transfer legislation and an appropriation request of $75 million for new construction and renovation will be submitted to the Congress for its approval.

### COST CONTAINMENT

Access to adequate sources of health care involves removing a major barrier to care—excessive cost. The professional standards review organizations (PSRO) program is aimed at assuring high quality care while reducing its cost. The 1977 budget level of $62 million, which reflects the impact of the recently enacted amendments to the Social Security Act, will provide for the development of PSRO's in all 203 areas nationwide. Of these, approximately 127 will actually be performing reviews of rospital admissions in fiscal year 1977. We estimate that 3 million admissions of medicare and medicaid patents wll be reviewed in 1977.

Also contributing to cost containment are the efforts of the National Center for Health Statistics, and the National Center for Health Services Research, which maintain a reliable, general purpose statistical data collection system. The information provided by the Center serves as an important data base for measuring the growth of health care costs as well as for supplying vital statistical data for proper health planning.

### RESEARCH

Health research into the cause of disease remains a most essential element in the improvement of health status. Because of continued emphasis on the Federal role in biomedical research, a budget of $2.2 billion is proposed for the National Institutes of Health (NIH). The

NIH request proposes to increase research in the emerging areas of immunology, aging, and environmental health. Other increases will provide for expanded heart and lung research and basic research on the cellular and molecular basis of disease and will permit the first phase of construction of an ambulatory care facility, which is designed to provide a more economical and effective means of evaluating the benefits of NIH research findings. In addition to biomedical research, we are also requesting funds for behavioral research in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and for health services research in the Health Resources Administration. ADAMHA research provides investigation in the vital areas of mental health, drug abuse, and alcohol, while health services research has as its primary purpose improving the way health services are organized, delivered, and financed.

I and the representatives of the health agencies will be pleased to answer any questions you may have.

### IMPROVING THE NATION'S HEALTH STATUS

Mr. FLOOD. Well Doctor, from the information contained in that report you are talking about entitled "Health, United States, 1975," it certainly appears that this Nation has improved the health status of its citizens. You indicated to us that the programs that we have funded, for the past decade anyhow, have been very successful. Do you have any data at all showing which of these programs has contributed more significantly to improving the overall health status of the United States? I ask you that because there is so much money available for evaluation—evaluation—we hear that all of the time up here, and certainly that kind of information should be available.

That kind of information seems to be so very useful to any kind of sound and logical allocation of the funds made for your health resources. What about that?

Dr. COOPER. In many respects, Mr. Chairman, that is a difficult question to answer.

Mr. FLOOD. That's why I asked it.

Dr. COOPER. Let me try to answer it in this way. The real bottom line, as they say in this city, is the reflection of where the improvement is.

The ultimate purpose of each program in their mandated endeavors is to reduce death and disability by providing service in certain specific areas, and item by item in that health status report you can see which ones succeed in achieving their purposes—that is if you want to use outcomes as the basis for success, or evaluation.

Mr. FLOOD. Use what?

Dr. COOPER. Outcomes, that is whether or not there is less heart disease or whether or not there is improvement in the maternal and child health morbidity and mortality statistics. In that sense the best indicator of evaluation is the real status itself.

There is a second dimension, however, to the question of which programs are performing efficiently. These are usually the so-called evaluation studies to which you refer. In my opinion, after reviewing both the evaluation reports and the health statistics themselves, I think the ones that are those of the National Institutes of Health, which have contributed a lot of basic knowledge and have increased

our ability to change the practices of medicine and to eliminate some diseases. Second, the programs in medical manpower development, where we have, in part, provided this change in trend toward who is using what services and where they are being utilized. Now, coupled to that are the special categorical service programs that have been initiated to combat certain selected health deficiencies in our population.

Part of the improvement that we are seeing, for example, in the migrant population, is a reflection that several hundred thousand people are now obtaining health services that they previously did not obtain. And I think I could go down virtually every program in that regard, so that I would have to try to weigh for you relatively the number of people impacted and the relative management effectiveness of each program.

PROGRAM ACCOMPLISHMENTS

Mr. FLOOD. Well, I understand that, but I thought you had two or three that would stand out that you want to mention.

Dr. COOPER. Well, there is one program that I do want to call to your attention, which I think is a magnificent accomplishment on a worldwide basis, that stems from both the development of knowledge through research and the development of service techniques, outreach methods and control technology. That is the imminent worldwide eradication of a disease for the first time. Eradication, I don't mean control, but eradication and that is smallpox. I think that is a magnificent accomplishment. If I had to point out one area that shows success and that demonstrates the importance of the effective interaction of the total system, it would be this accomplishment.

Mr. FLOOD. Well, polio has pretty much disappeared in the country, hasn't it?

Dr. COOPER. Polio has been a magnificent story as well. I am a little disturbed in this regard that recent statistics indicate that the number of children coming to school without proper immunization has increased significantly.

Mr. FLOOD. How many were not immunized last year about? Do you have a figure?

Dr. COOPER. About 40 percent of the children through age 4.

Mr. FLOOD. How many last year had polio, how many this year?

Dr. SENCER. I don't have an actual vaccine distribution, but the number of children adequately immunized against polio in 1973 was 71 percent and in 1974 it was 73 percent.

The Bureau of the Census hasn't given us the 1975 figures yet.

Mr. FLOOD. Is it going down?

Dr. SENCER. It's not going up dramatically, but it is not falling precipitously either. But I think it is important to point out we only had one case of polio last year, that we can say actually was acquired in the United States. There were a total of seven cases of polio, and six were imported.

Mr. FLOOD. I was afraid that because people thought it was all taken care of that immunization would go down dramatically.

Dr. COOPER. Yes; I am concerned about that, too, and in fact, we are trying to mount in the private sector an awareness campaign that these kinds of things must go forward.

Mr. FLOOD. Incidentally, Doctor, which one of your agencies prepared that report, "Health, United States, 1975"? They ought to have a pat on the back for that. We have had a lot of good comments on that.

Dr. COOPER. Yes; I think that was an outstanding response to the Congress and, as you know, an annual update is required. The report was prepared by the National Center for Health Statistics in association with the National Center for Health Services Research in the Health Resources Administration. I agree with you, they deserve a considerable commendation for the quality and the timeliness of that report.

Mr. FLOOD. Well, now that we have discussed the fact that we are all very proud, all very proud now of our efforts of improving the Nation's health, how do you reconcile that with this 1977 budget in which you propose to cut the controllable portion of the health budget by approximately $700 million—that is below the 1976 level. Don't you want to keep the momentum going?

Hopefully we are not going to be satisfied with an infant mortality rate of 16.5 percent per thousand live births?

Dr. COOPER. No, sir. We are not satisfied with any condition with which we feel we can make progress in preventing disease.

BUDGET REDUCTIONS

Mr. FLOOD. Good. Well, what about this $700 million cut; first everything is great; now we are going to cut it $700 million.

Dr. COOPER. Let me say I do not believe we can equate the progress on a one-to-one basis or in a linear fashion with the dollar-for-dollar allocation in the budget. I think what we have to try to do is try to utilize, to the best extent possible, the resources which we have available to us for taking advantage of the opportunities which we have.

I think within any program there is attrition, termination for certain situations, and if the resources available to us from time to time do not allow additional increments, then I think we can continue some momentum by skillful management and proper allocation of the resources.

Mr. FLOOD. $700 million.

Dr. COOPER. Well, that is about a 14-percent decrease, Mr. Chairman. We do not think that that will impose a mortal wound on the process. We think that within the context of the opportunities we have, we can keep the momentum going.

Mr. FLOOD. Just remember we talked about it now.

Dr. COOPER. Yes, I will, sir.

INFANT MORTALITY

Mr. FLOOD. Now, in your statement you mentioned again that the U.S. infant mortality rate is 16.5 percent and we rank 15 in the world on that statistic. That by the way, is the same thing you told us last year.

Dr. COOPER. That is correct.

Mr. FLOOD. What did we do, did we hit the bottom? Can't we get that statistic lower?

Dr. Cooper. Yes, sir, we can. I think a great deal of progress can be made in this area, and we have looked at this closely. I think that the best approach to this will be a better effort on the problem of teenage pregnancy.

We have not done well in this area. Now, if I had the magic power to reduce teenage pregnancies, especially the ones that are not planned in a family setting, then I think that we could easily move from 15th to 1st.

These are the significant areas of low birth weight, poor preparation of the mother. The education of the teenager has been focused on the young female and the question usually concerns sex education, rather than about total education about the social, economic, and cultural factors that are involved in this. We have not done this on a broad approach.

We have not approached the male aspect of this, and I think there are many things we can do regarding the issue of teenage pregnancy which we will be recommending to the Department. Within the Public Health Service, we hope to address this problem in a more aggressive manner.

Mr. Flood. Now, you also said in your statement that a very large percentage of pregnant women do not start any prenatal care during the first 3 months of the pregnancy. Why in the world is that? Is it because the medical care is not accessible, or that they simply can't afford the medical care?

Dr. Cooper. Well, there are some cases in which medical care is not accessible to them either on financial or geographic basis, or perhaps they are ignorant of where to obtain care. In a lot of those cases the problem might be because they are ashamed or unwilling to go to the doctor, and it is a vital period of time.

I do think if I could solve it just on a technical service basis by removing all financial barriers, I think next year I would come to you and still report we are 14 or 15.

Mr. Flood. All right, you are talking about all of the existing health programs, which one of the existing health programs is responsible for resolving the problem you are talking about.

Dr. Cooper. We think there are several programs in which this new approach needs to be inserted.

Mr. Flood. Which one is responsible?

Dr. Cooper. Well, in our public health programs the maternal and child health program and the family planning programs are the key areas of interest. But they are not the only ones that are important to this area within the Department, or within the Federal Government's programs.

Mr. Flood. What about community health centers?

Dr. Cooper. Regarding the community health centers program, we cannot isolate this problem from the total system of care. That is why the educational effort can't be relegated to only one program, although we can decide on a lead agency to take responsibility for it.

Mr. Flood. What about the National Health Service Corps?

Dr. Cooper. Absolutely. I think the problem of teenage pregnancy needs to be brought to a high degree of awareness in all of those programs.

MATERNAL AND CHILD HEALTH

Mr. FLOOD. All right now. Now we have made the case very clearly that a great deal of work, much work, has to be done in order to reduce infant mortality. Well, will you explain to the committee in view of that why are you reducing the maternal and child health program $110 million.

Dr. COOPER. The maternal and child health program is one of the service programs of a group for which we have recommended two kinds of change, Mr. Chairman. One of these we discussed with you last year. The committee was not very receptive at that time to a recommendation of a reduction in the Federal portion of their operational funds, as you will recall.

In addition, this is one of the 16 programs that is recommended for incorporation into what is called the block grant, or the Federal Assistance for Health Care Act. Our interpretation here is that the effort might most efficiently and best be done if it is left to the States and local jurisdiction to select out their priority needs. They can provide services to these target populations with a minimum of Federal consultation in achieving these health objectives.

Mr. FLOOD. A $110 million cut!

Dr. COOPER. We are recommending a total reduction of the $110 million.

Mr. FLOOD. Yes; that's what I said.

Dr. COOPER. Yes, sir.

Mr. FLOOD. You have stated the question, now what's the answer?

Dr. COOPER. Well, I think what I have tried to point out is that these problems can best be addressed by the $10 billion block grant program including medicaid. Now, let me say that one of our concerns has been that these kinds of services ought to be available in the medicaid type operation to the disadvantaged.

Now, I recognize that there are certain parts of maternal and child health activities that are not only oriented toward the disadvantaged but are aimed at research and resource development. In the service area there are other alternatives for potential reimbursement for this kind of care. And this is what we are trying to actually simplify, to change the question of eligibility of the people in relation to the providers of care in the community.

FORWARD PLAN FOR HEALTH

Mr. FLOOD. Well, all right, we are aware of this forward plan for health that is for fiscal 1977 to what, fiscal year 1981?

Dr. COOPER. Yes.

Mr. FLOOD. All right, it is an excellent document, let me say that.

Dr. COOPER. Thank you.

HEALTH PRIORITIES

Mr. FLOOD. All right, it appears though this excellent document was not considered in the preparation of the 1977 health budget. Let's assume you had available the same total of health funds now that are currently contained in the 1977 budget. How would you distribute those funds in using your forward plan?

Dr. COOPER. Well, I think in the 1977 current budget there are some initiatives that have resulted from adopting the recommendations that we outlined as the directions that the system needs to take. The ones I pointed out were the National Health Service Corps activity, certain of the other manpower initiatives, the clinical laboratories improvement, the NIOSH activity and so on.

Mr. FLOOD. Now, if you had that, how would you distribute; what would you do?

Dr. COOPER. If I had all of the money I wanted available?

Mr. FLOOD. In 1977?

Dr. COOPER. And the economy were such, and I could have the option——

Mr. FLOOD. That is the question, what would you do with it?

Dr. COOPER. If I had the option of redistributing, as I would like it, my emphasis would go in the following half a dozen areas. As I pointed out, we have to make a commitment to cost containment, and I would emphasize the areas in our public health service program that are oriented to those.

Mr. FLOOD. What are the others now?

Dr. COOPER. I would say they are the major areas of prevention oriented toward environmental and occupational programs, child health and health education, and the adjustment in the maldistribution of the medical effort including the manpower effort and a maintenance of a vigorous frontline program in the areas of biomedical behavioral and health service research.

BLOCK GRANT PROPOSAL

Mr. FLOOD. I want to tell you why we ask the questions "if you had the money for 1977." This budget you are talking about would consolidate, would fold these grant programs into a block grant. Just a few minutes ago, both of us talked about substantial improvements, great improvements we have achieved in the Nation's health. Obviously, many of these health service programs that we have talked about made material contributions to that improvement, obviously. Have you conducted any studies before you came up here to determine if we can continue to show the same kind of improvements, the same degree of progress, the same quality of improvements in the Nation's health status under this block grant program? Have any studies been done on that?

Dr. COOPER. I do not have a specific study by which I could demonstrate for you the ability to move forward at the same pace, or in the same areas.

However, I think it is not the administration's view that the health objectives themselves, the elimination of the specific diseases or the categorical activities would cease to be the objectives of the States. I have met with the State and territorial health officers and representatives of State and local government, and I am convinced that their interests in serving these needs are just as profound as our own, and I consider them honorable men and women. I think what I did learn from them is that some of them have a more weighted interest in different kinds of programs but that they are currently bound by the Federal matching requirements and the various Federal categorical programs from addressing the priorities.

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Mr. FLOOD. Let me ask you this question: Do all of the States now have the capacity to deal with this wide range of health programs that are called for under this block grant program? Do they?

Dr. COOPER. I think to be very candid with you, Mr. Chairman, the States' capacities in this area vary tremendously. They have had different degrees of technical assistance, different degrees of local investment, and different capacities for many years. I think the ability to provide a comprehensive health care plan, as our draft legislation requires would vary greatly among the States. In other words, we would have to provide them with significant technical assistance, which we would be prepared to do.

HEALTH STATISTICS

Mr. FLOOD. Well, in the last part of 1975 we were reading about these very startling increases in the cancer death rate. Just a few weeks ago we were told that's all a mistake. What caused this kind of shocking error? And what in 1977 are you going to do to be sure that we improve data of that kind?

Dr. COOPER. Let me say that I do not consider this experience a reflection of technical error as its main cause.

Mr. FLOOD. Well, what was it?

Dr. COOPER. What I think we are seeing is a reflection for the great desire for openness, instant reporting, inability to see the trends and do the statistical evaluation over a period of time that is required for the information to mature.

There were certain things in the development of that interpretation and in the ironing out of those trends that only time could provide for, and a reflection backward on what the sampling base might have been or might not have been. This is not to excuse the potential of miscalculation or missampling.

Mr. FLOOD. What do you have in the 1977 budget that is going to improve or to prevent that kind of thing?

Dr. COOPER. Well, I think there are two things I would like to do. One is to assure our commitment to the National Center for Health Statistics, and the second is to assure the continued improvement in the integration of our health statistical policy within the Department, so that all of the programs have maximum access to the best information, as these are required to be reported.

I think you are aware that because of the Freedom of Information Act and the other openness requirements of all of our deliberations, that trends and initial reports often come to public light before they are finalized in their interpretation.

Mr. FLOOD. Well, do you think your 1977 budget is going to be able to provide and do that very thing?

Dr. COOPER. We think we shall be able to maintain——

Mr. FLOOD. Maintain?

Dr. COOPER. Maintain a suitable effort in health statistics with this level of activity.

HOME HEALTH SERVICES

Mr. FLOOD. Well, now you mention in your statement that one alternative to providing care for the elderly is through home health

services. You stress that pretty strongly. Well, what are you doing to encourage the extension of home health services?

Dr. COOPER. Within the existing authorities of the Public Health Service Mr. Chairman, we have one or two avenues by which we can stimulate activity in this regard.

The main activity or the main lever of improving home health services is in the reimbursement systems, particularly medicaid and medicare, for which I do not have principal responsibility, although we do have common policy discussions. We have urged the Secretary and the other agencies to work in this direction, and it is my understanding that new regulations in this area are in the process of being finalized among the three agencies.

Mr. FLOOD. What do your agencies know about the effectiveness and the quality of the existing home health services?

Dr. COOPER. Well, we have conducted experiments under section 222 of the Social Security Act in our Bureau of Quality Assurance and in our evaluation programs which are giving us more and more information about improved human effectiveness by introducing alternatives to institutional care.

We are providing this kind of analysis and policy advice. We would like to continue to participate in the support of the studies that affect the reimbursement policy, and I think that those authorities are clearly within the scope of our own agency responsibility.

Mr. FLOOD. When you consider the cost of nursing homes, it certainly seems very important to everybody. Isn't it imperative that we know as much as possible about the potential of home health services?

Dr. COOPER. Absolutely. I believe since home health is a growing trend that we need to have such information and we will get it.

Mr. FLOOD. All right now, last year we talked and we talked at some length about the improvements in the nursing home facilities and the improvements in the quality of the care provided. What progress are you making in that area and what can we expect in the future on those two things?

Dr. COOPER. I think in the past the emphasis had been, as we discussed with you last year, on responding to the tragedies that had occurred in increasing numbers because of fire and safety violations and inadequate facilities. Our emphasis now is changing to the issue of quality of care itself. And in our initial survey and studies in this regard we have identified factors which are beginning to enable us to change that aspect of quality of care. These relate to factors such as who is looking at the medications that the patient is getting when the patient is not properly visited on a professional basis in the institutional setting.

This also involves such questions as what kind of dietary management is being given and what kind of thought is being given to the preparation of a proper diet and exercise program.

Our focus will be on the result of studies just completed, released in the recent months, on the emphasis of quality of care rather than on just the quality of the facility.

## HEALTH EDUCATION

Mr. FLOOD. Well, now, another point we talked about last year, and another point you tried to make just a little while ago and in your

statement, involves improvement that could be made if we could show individuals the, what did you say, "the proper way to live."

Dr. COOPER. Yes, the individual.

Mr. FLOOD. I suppose you are talking about conducting health education——

Dr. COOPER. In the broad sense, yes, sir.

Mr. FLOOD. Now you have many programs, you are conducting various sorts of health education, are you not?

Dr. COOPER. Yes, sir.

Mr. FLOOD. As the Assistant Secretary of Health, how do you coordinate all of these efforts so that you reach your target of getting this message to the high risk group? How do you get them altogether? Do you have a formal plan?

Dr. COOPER. Yes. We have responded to the questions previously on this and have implemented the necessary plan and procedure through the various agencies, all of which, as you pointed out, do have specific activities in health education. These are usually in the categorical programs and amount to about $80 million in effort. It does need coordination, integration and leadership, because there are certain areas where we miss out and one of them is in teaching the people how to use the health care system, not only to stop smoking cigarettes and drinking, and so on, but also to tell people where they should go to get what kind of health services.

Mr. FLOOD. Right, that's why I asked.

Dr. COOPER. And we will submit that for the record, and Dr. Sencer will do it.

COST CONTAINMENT

Mr. FLOOD. You used the phrase "excessive cost" as a barrier to health care and then you went on at some length to talk about the PSRO's that would reduce the costs. Will you explain to us how the PSRO program is going to help relieve the cost problem and reduce the cost to the patient.

Dr. COOPER. Yes, sir. It is one of several mechanisms to reduce cost. It's not the only factor and let me also say in a preliminary answer that the principal benefit from the PSRO program in the long run will be increased quality of care.

But in approaching the quality of care issue, what we find is that if the quality is right, and the selection of hospitalization is based on medical necessity, on what the patient needs and not on what his insurance policy pays for, then we can begin to associate cost with quality. We can also tie cost containment to the elimination of unnecessary or inappropriate activities. On an anecdotal basis I could submit for you at some length, if you would like, some of the earlier experiences with some of the conditionally operating PSRO's in which we are beginning to see reduction of hospital stay.

PSRO'S

Mr. FLOOD. All right. What experience have you had with the few operational PSRO's that are actually reducing costs?

Dr. COOPER. I think in the early experiences, we are seeing savings in hospitalization per incident that range from——

Mr. FLOOD. You are talking about the operational PSRO's?

Dr. COOPER. Operational PSRO's, the ones actually doing review of hospital admissions. In those areas we are seeing a reduction in hospital stay for conditions that used to take some days by a variation of 1 to 1½ days. Now, maybe that sounds like a very trivial number, but if you keep in mind that if you were to reduce each hospital stay in the country by 1 day that alone would reduce health care costs by approximately $1 billion. Every fraction of that is a significant savings of hundreds of millions of dollars. Our initial experiences in the early locations where there is experience to review, is giving us data showing that in Mississippi, for example, over a period of 6 months there was a reduction in the medicare stay from 9.7 to 9.1 days.

In Montana there has been a reduction in average stay from 6.2 days to 4.2 days. I will be glad to submit for the record the early experiences on this.

Mr. FLOOD. All right.

[The information follows:]

IMPACT OF PSRO REVIEW

It is clearly too early to assess the true impact of PSRO activities. Very little data is available at present due to the short time that these organizations have been conditional and performing binding review. We can, however, indicate that conditionally designated PSROs have found evidence that where PSRO review is implemented, hospital lengths of stay are shorter than under previous conditions.

For example, length of stay data available from four newly designated conditional PSROs (South Carolina, Idaho, Hartford County, and Greater Oregon), showed an average decrease of length of stay of 22.75 percent. For medicaid patients, length of stay declined from 7.94 days to 5.68 days. At an average cost of about $100 a day the resultant rough estimate of the savings in basic hospitalization costs was approximately $223 per episode of hospitalization. For medicare patients, length of stay declined from 11.21 to 9.3 days. At a cost of $100 per day, the resultant saving in basic hospitalization costs can be estimated to be approximately $189 per episode of hospitalization.

It should be emphasized that the more startling rate of change for length of stay among new conditionals, 22 percent as compared to 6 percent for the original conditionals, is a function of their state of development. The larger changes in length of stay may be expected when review is first implemented. While we are not certain we can generalize their level of these savings to all 11 million medicare and medicaid admissions we believe PSROs will function in a most cost effective manner.

In a study performed by the Colorado PSRO of utilization rates in acute care hospitals, adjustments were made in the data to account for a general decrease in utilization rates which is being experienced now throughout the country. The data from the Colorado PSRO, which has been a conditional PSRO since June 1974, was then compared to data from two States (Nebraska and Kansas), where no conditional PSROs have yet been established. Even though its data had been adjusted, the Colorado PSRO still indicated a decrease in utilization rates.

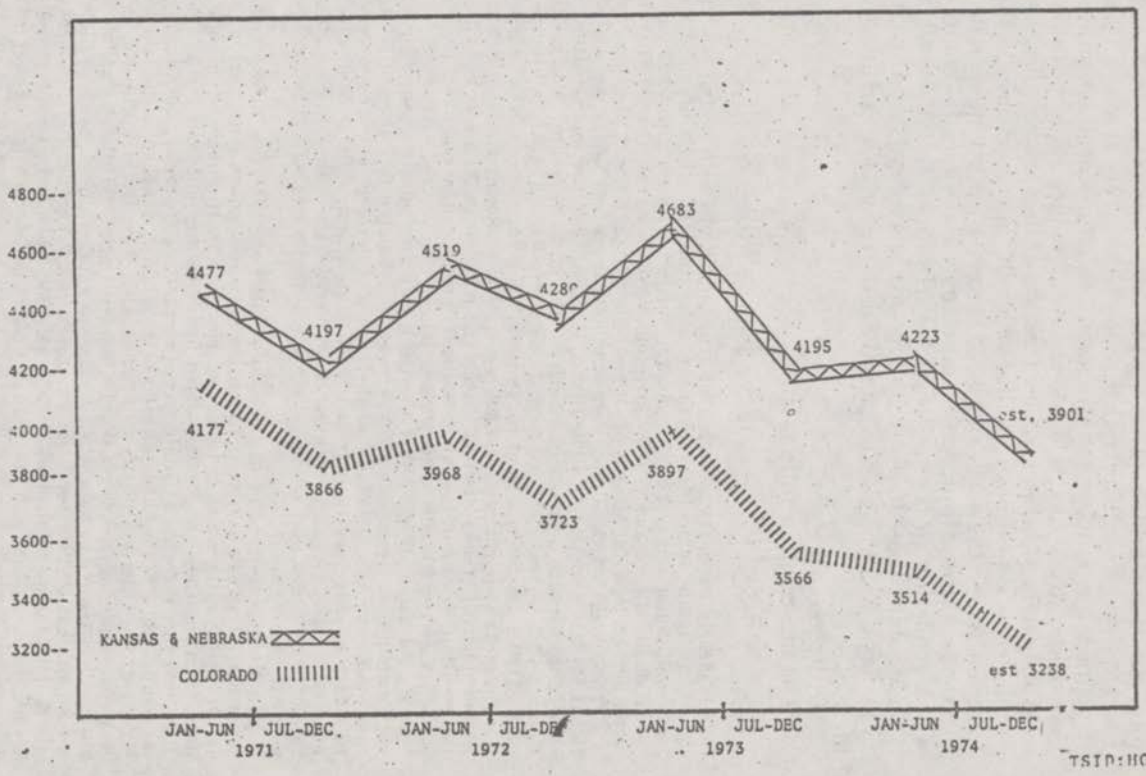
A comparison of data regarding patient days per 1,000 eligibles utilization rate between Colorado and Nebraska and Kansas (states similar to Colorado but with no conditional PSROs yet), shows quite similar characteristics in seasonality shifts until the first 6 months of 1974, a period which coincides with the current level of implementation in Colorado of PSRO inpatient review. At that point, both Kansas and Nebraska again follow the pattern established in 1972 and 1973, and swing upward while Colorado, unlike its own pattern from the previous 2 years, continues downward.

Colorado continues to increase the gap in patient day utilization rates compared to that of Kansas and Nebraska from 92.4 percent in 1971 to 83.1 percent in 1974. Comparing Nebraska against Kansas shows a relatively constant ratio going from 95.5 percent in 1971 to only 95.6 percent in 1974.

The inpatient charges for each eligible in Colorado compared to Kansas and Nebraska decreased by 10 percent while comparing Kansas with Nebraska indicates an increase of 4 percent. Comparing each group against base year 1971 shows that the 1974 dollar charge per eligible in Colorado increased only 11.1 percent compared to a Kansas and Nebraska aggregate of 21.2 percent.

UTILIZATION RATES

PATIENT DAYS PER 1,000 ELIGIBLES



MEDICAL CARE EVALUATION STUDIES

In addition to information on the impact of PSRO hospital review, we have received some information on medical care evaluation studies which have been conducted by the PSRO's and the effects on institutional care and medical education.

In the San Joaquin Area PSRO, a transfer of medicare patients with tuberculosis to long-term-care facilities resulted from concurrent review and criteria development. It was the community practice, while such a patient was in an acute facility, to require three negative cultures before transfer to a long-term-care facility. However, each culture required 6 weeks with 2-week intervals. Thus, patients would be in an acute facility for about 22 weeks before transfer to a long-term-care facility. The long-term-care facilities insisted on this because of fear of losing their licensure and fear of infecting other long-term-care patients.

The PSRO brought together representatives of the long-term-care facilities, the county public health department, the acute hospital discharge planners and, most important, local pulmonary disease specialists. It was generally agreed that no culture was necessary and only two smears were needed, one at the beginning of treatment, and one showing decrease in bacteria count after treatment. Therefore, stays for tuberculosis in acute hospitals have been reduced from 22 weeks to 2 weeks. Further, while some patients go to a long-term-care facility after 2 weeks, many can be sent directly home on medication.

In the western Massachusetts PSRO a medical care evaluation study was performed to study the apparent excessive use of antibiotics in patients undergoing vein ligations and stripping for varicose veins. At one hospital, antibiotics were used for this category of patients in 35 percent of the cases during a 1-year period, with a high of 60 percent during the last quarter of 1974. The professional activity study (PAS) norm for this parameter for hospitals in that area was 11 to 27 percent for the same period of time.

The study group included 96 patients with vein ligations and stripping who had been discharged during 1974. The criteria and standards used were established by the surgical service on June 7, 1975, and stated that no patient in this category should receive antibiotics, with four specific exceptions.

Analysis of the cases showed that the use of antibiotics was indicated in 22 percent of the cases as compared with their actual usage in 35 percent of the cases. However, further analysis showed that antibiotic usage in two additional cases was justified under exception and that nine other cases would have qualified under exceptions were it not for the fact that antibiotics had not been started preoperatively. Had antibiotics not been used in these 11 cases, the hospitol's usage of antibiotics would have fallen below the PAS normative range. This proved that the criteria and standards adopted by the surgical service for this parameter were realistic, but that a problem existed in failure to put knowledge into practice. It was recommended that, henceforth, all cases of vein ligations and stripping be monitored during their hospital stay for the appropriateness of antibiotic usage, and that a similar study be repeated for 1975 discharges when data is available.

Other examples of PSRO hospital medical audit activities indicate similar favorable impact on hospital practices and the quality of patient care. As we have indicated, although the value of improved quality of care is more difficult to calculate, it is, nevertheless, very important. Improved quality can also result in shorter lengths of stay, as well as reductions in inappropriate services. Improved quality also can mean improved health status resulting in reduced need for health services.

A word of caution on expectations of a PSRO's ability to decrease costs. A PSRO is primarily a mechanism for assessing the quality and appropriateness of medical care services which are delivered. Other elements such as financing systems, program coverage decisions and rate-setting mechanisms primarily address cost controls. The quality assurance activities of PSRO's may increase the utilization of some services while decreasing that of others. An effective PSRO program can, however, assure that whatever Federal dollars are spent on health care will only be spent on appropriate quality care.

Dr. COOPER. Now, I don't want to overpromise in this area, Mr. Chairman, and let me just say that this kind of continued saving should not be anticipated. I think you reach a point in which there is a proper hospitalization period which is required by medical neces-

sity. We should not expect a continuing improvement once this proper hospitalization period is reached.

But then we expect to see savings because people will be reviewing whether the proper tests are being done, and whether the proper drugs are being administered. The clinical laboratories programs as recently demonstrated on television is a multibillion-dollar business where opportunity exists for great savings if we can address the issue of what is proper to be done, and what is not.

I am not talking about a fiscal audit but a quality audit.

Mr. FLOOD. In the PSRO operation?

Dr. COOPER. We expect that to be covered in the PSRO operation.

PUBLIC HEALTH SERVICE HOSPITALS

Mr. FLOOD. In your statement you mentioned that the Department is going to be submitting a legislative proposal to Congress to close the Public Health Service hospitals. Has that proposal been submitted?

Dr. COOPER. No, sir, it has not; as required by the law, we have a series of responsibilities we have to execute before we can submit that proposal. An essential part of that responsibility is to review this proposal in the various affected communities and get approval from the local planning agency and then the State planning agency.

Mr. FLOOD. Will this 1977 budget permit you to operate all of these facilities now in accordance with the legislative requirements in the law, Public Law 93–155? Are you going to be able to do that?

Dr. VAN HOEK. The answer is "No."

Dr. COOPER. Not up to the same standard in its entirety. Is that correct?

Dr. VAN HOEK. The budget that you see before you is predicated on the approval of the legislative proposal for the closure of the Public Health Service hospitals.

Dr. COOPER. It does permit the hospitals to continue to operate through 1977 pending the completion of the actions required in the proposed legislation.

Mr. FLOOD. How much more do you need?

Dr. VAN HOEK. Well, to operate the hospitals in full compliance with Public Law 93–155 with no transfer or closure would require another $26 million.

CLOSURE OF PHS HOSPITALS

Mr. FLOOD. Now, it seems to us that in order for the Department to close out these hospitals that it is going to take a considerable amount of planning and negotiating and discussion with the health care providers back at the local level, as well as the State agency that is going to be involved in this thing. All right now, how long is it going to take to complete that process, and how far into this process have you got at this point in time?

Dr. COOPER. Well, I initiated the process some time ago, and wrote to the communities involved and the responsible officials involved.

I have been informed by them that the process of review could not be accomplished within the time schedule that I had set. I had expected to have the process completed by April 1, and had hoped then to be able to submit or recommend to the Secretary that the

preliminary work had been done. The word we are getting now is that the A and B agencies will not be able to meet that requirement. I do not have a specific date as yet from all of the agencies as to when this would be done.

This will be no impediment to the Department in its preparation of the recommendation itself, but the preliminaries are holding us down.

Mr. FLOOD. Do all of these PHS hospitals, do they all meet the life safety standards that HEW requires of all non-Federal institutions?

Dr. COOPER. Perhaps Dr. van Hoek could comment on this.

Mr. FLOOD. And if they don't, how much would it cost to bring them up to standard?

Dr. COOPER. These are all currently JCAH accredited.

Mr. FLOOD. Do they meet them?

Dr. COOPER. Not all requirements for every State and local jurisdiction.

Mr. FLOOD. All right, Now, if they don't, how much will it cost to bring them up to standard?

Dr. COOPER. We will have to provide you that information for the record.

Mr. FLOOD. Yes, I can see that.

[The information follows:]

COSTS TO MEET SAFETY STANDARDS

The Bureau of Medical Services has identified over $78 million of projects in its 5-year plan covering safety, regulations, and accreditation deficiencies. It is estimated that 60 percent or $47 million of these costs can be directly attributed to correcting safety violations and hazards. However, this type of project is usually incorporated with facility and program improvements. Therefore, the total $78 million is required to update the hospitals to community safety and accreditation standards.

HEALTH PLANNING AGENCIES

Mr. FLOOD. In your statement you also referred to building this nationwide network of planning agencies with the purpose of improving the access to health care. Fair enough. Now, of course, we agree with that, especially if you are going to get ready for anything like national health insurance. But what about your new proposal? Wouldn't you lose the ability to build this nationwide network if the program were to become part of a bloc grant proposal? Wouldn't you have 50 different operations going on, with different kinds of quality, 50 things? How do you fit this goal into a bloc grant concept?

Dr. COOPER. The point that you make is that the planing program is recommended for inclusion into the Federal Assistance for Health Act.

What I was indicating in my statement is a commitment to the objectives of the Planning Act. We think it is very important that you have a mechanism for designing local referral patterns, to prevent unnecessary duplication of capital resources allocation, and to have some system by which local communities can determine these patterns. We think that the specifications we have devised for the bloc grant or the Federal Assistance for Health Care Act go beyond what is specified in Public Law 93-641 and makes a stronger commitment to that.

Mr. FLOOD. You don't think in the bloc grant you reduce the ability for a nationwide network. You don't think so?

Dr. COOPER. No, sir. As you are probably well aware, we have designated most of the 211 areas on the basis of State Governors' wishes. I think the main difference is that there is a change in the accountability for the process to the Governors rather than to the Secretary.

Mr. FLOOD. You are not going to get 50 different kinds of networks?

Dr. COOPER. Oh, I think there is the potential that they would all be different, but in the real world they would have certain things very much in common, and certain things completely different. We would expect that even in the current system, because the strength of the current proposal is that there would have to be local control over the planning decisions.

And there should be differences. What we have currently provided is a system of guidelines, not regulations, recommending standards. This is compatible with the block grant proposal which would encourage the development of standards which could be recommended for the consideration of each State, just as they are recommended now for the consideration of each local HSA.

PRIVATE FUNDING AND FEDERAL HEALTH PRIORITIES

Mr. FLOOD. All right. Now, here is one thing we touched on a little last year. How do your agencies work with the private foundations, such as that Robert Wood Johnson Foundation you mentioned before? Aren't they investing pretty sizable sums of money to promote these out-patient medical care facilities all over the country?

Dr. COOPER. Yes, sir.

Mr. FLOOD. And that certainly seems to dovetail into your priorities.

Dr. COOPER. Yes, sir, I think it's very good. It's a very good relationship, and we have had very excellent cooperation from the private foundations like the Johnson and Kellogg Foundations.

Mr. FLOOD. How do you work with them?

Dr. COOPER. We sit down and talk with them about what their plans are and tell them what our plans and commitments are. We attempt thereby to avoid duplication and maximize the available national resources to tie to the national scope.

Mr. FLOOD. Maximizing of the investment of private and Federal funds?

Dr. COOPER. That's right, and we are trying to maximize that by not duplicating efforts and by trying to dovetail and integrate.

Mr. FLOOD. With a national goal?

Dr. COOPER. Yes, we try to agree to a national objective and we try to define what is the appropriate Federal role, and what is an appropriate non-Federal role. They take up the slack for us.

COORDINATION OF FEDERAL HEALTH STATISTICS ACTIVITIES

Mr. FLOOD. Just so we are looking at this. Most of these health programs seem to have their own data collection systems all over the place, I guess in order to collect data for their particular area of responsibility, nationally. How does your Office coordinate all of these individual data systems and how do they tie in with the National Center for Health Statistics that we finance?

Dr. COOPER. Two years ago we created a health data policy committee that brings together all of these agencies that have ongoing programs collecting statistics in the health area. That includes not only those within the Public Health Service, but within the other agencies that serve the system. The Director of the National Center for Health Statistics is the co-chairman of that group.

The other co-chairman is the Chief of my Office of Policy Development and Planning, so that I am continually informed about what the problems are, what the overlaps in jurisdiction are and what the funding distribution problems are. By discussing this integration effort with the Secretary, we have been able to resolve policy issues, questions of duplication of resources and computer needs.

Mr. FLOOD. I tell you what you do for the record. Supose you give us a list of the programs?

Dr. COOPER. Yes, sir.

Mr. FLOOD. Give us a list of the programs we support, including for instance, epidemiology, biometry activities, all of those.

Dr. COOPER. Yes, sir.

Mr. FLOOD. Also, when you do that, we are concerned about the total amount of dollars involved.

Dr. COOPER. We will give you that compilation. We have another new plan document in which this is already completed.

Mr. FLOOD. All right.

[The information follows:]

The following information is provided from the Health Statistics Plan, Fiscal Years 1976-1977, prepared under the direction of the Health Data Policy Committee. Information was obtained from an inventory of health statistics activities of the agencies of the Public Health Service, Social Security Administration and the Social and Rehabilitation Service in the Department of Health, Education, and Welfare.

Two tables are presented, one which lists expenditures reported by agencies for general purpose statistical activities (surveys and censuses) covered in the Plan, and another which provides expenditures for program management health data systems for each agency. The combined expenditures for both types of health data amounted to $47.6 million in FY 1974, $37.2 million for general purpose health information and $10.4 million for program management health data systems and projects.

The Health Statistics Plan is now being updated and more current figures will soon be available.

Table 1: Expenditures reported for General Purpose Health Data by Agency and Subject Area, FY 1974

| | Total | Health Status | Health Facilities | Health Manpower | Utilization | Health Care Expenditures | Other |
|---|---|---|---|---|---|---|---|
| | (dollars in thousands) | | | | | | |
| Total | 37,209 | 18,112 | 3,106 | 2,278 | 5,690 | 1,623 | 6,400 |
| HRA | | | | | | | |
| NCHS | 20,400 | 7,650 | 2,300 | 500 | 3,850 | 500 | 5,600 |
| BHRD | 1,901 | 4 | 67 | 1,577 | 180 | 73 | - |
| OASH | - | - | - | - | - | - | - |
| ADAMHA | 833 | - | 736 | - | 97 | - | - |
| NIH | 10,140 | 10,000 | - | 65 | - | 75 | - |
| HSA | 1,524 | - | - | 136 | 588 | - | 800 |
| CDC | 461 | 458 | 3 | - | - | - | - |
| SSA** | 1,950* | - | - | - | 975* | 975* | - |
| SRS | - | - | - | - | - | - | - |

*Excludes all in-house computer operating charges as well as costs of the Annual Survey of Independent Health Insurance Plans.

**Data reported by Agency as program specific but classified for purposes of this plan as general purpose.

Table 2: Reported Expenditures for Program Management Health Data Systems and Projects by Agency and Fiscal Year

| Agency | Fiscal Year 1974 | 1975 | 1976** | 1977** |
|---|---|---|---|---|
| | (dollars in thousands) | | | |
| Total | $10,392 | $12,908 | $12,435 | $10,912 |
| ADAMHA | 1,973 | 2,226 | 1,986 | 2,011 |
| CDC | 1,984 | 2,030 | 2,118 | 1,769 |
| FDA | 244 | 297 | 223 | 245 |
| HRA | 55 | 60 | 64 | 70 |
| HSA | 2,204 | 4,208 | 3,721 | 3,587 |
| NIH | 2,797 | 2,882 | 2,863 | 1,665 |
| OASH | 150 | 150 | 160 | 170 |
| SRS* | 985* | 1,055* | 1,300* | 1,395* |
| SSA | - | - | - | - |

*SRS figures include an arbitrary allocation of 10 percent of grant funds for Medicaid Management Information System.

**Current Projections.

Source for Table 1 and Table 2: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Statistics Plan, Fiscal Years 1976-1977. Washington, D.C.: U.S. Government Printing Office, November, 1975.

DIABETES

Mr. FLOOD. You talked about the Diabetes Commission which recently submitted quite a plan to combat diabetes during the course of the year. In that report they stated the Federal Government is currently spending $43 million to combat that disease. All right now, does your 1977 budget call for any expansion in this diabetes control? What are you doing?

Dr. COOPER. There is no specific item in our budget that is earmarked diabetes. The diabetes program is carried out at the National Institutes of Health.

Mr. FLOOD. Which Institutes?

Dr. COOPER. Well, there is the primary focus in the National Institute for Arthritis, Metabolism and Digestive Diseases, but there are six others that have activities that relate to that. It is Dr. Fredrickson's responsibiliy to see to it that of the funds made available to the National Institutes of Health, that he maximizes the opportunities for diabetes research by recommending the allocation to the specific Institutes.

Mr. FLOOD. Well now, the Commission reports the current spending level is $43 million. Are you going to maintain the same level in the 1977 budget?

Dr. FREDRICKSON. We will at least maintain the same level, Mr. Flood, and attempt to augment it somewhat. It is largely based on the budget for the National Institute for Arthritis and Metabolic Diseases.

Mr. FLOOD. Did you call for any expansion of this diabetes research?

Dr. FREDRICKSON. Only a modest expansion this year in the program for that budget.

Mr. FLOOD. This year only modestly?

Dr. FREDRICKSON. Yes, sir.

Mr. FLOOD. Does the 1977 budget for NIH take into account the budgetary recommendations of this report from the National Commission on Diabetes?

Dr. COOPER. Well, let me take the responsibility for that, Mr. Flood.

Mr. FLOOD. Does it?

Dr. COOPER. No.

Mr. FLOOD. Why not?

Dr. COOPER. The budget was prepared before the Commission report was submitted.

Mr. FLOOD. What?

Dr. COOPER. The original budget recommendations were prepared and submitted before the Commission report came in, which is just recently. Their recommendations are in the process of being reviewed by the Director and the Department, and if there were opportunities that need to be addressed in the 1977 request, then we would have to speak to them in some other way.

Mr. FLOOD. But the 1977 budget did not take into account this Commission report?

Dr. COOPER. It did not take into account the Commission report.

Mr. FLOOD. That is all I have, Dr. Cooper, Mr. Michel?

Mr. MICHEL. Thank you, Mr. Chairman.

Dr. Cooper, first let me compliment you on your overall statement. It covered a lot of ground without being too detailed, but very comprehensive and interesting.

Every year I think we have had placed in the record those 13, 14, or 15 countries ahead of us in infant mortality, and I think we ought to have those countries enumerated in the record. But I would like to ask this:

I don't think there is much change in those countries, and their relative position, is there, in the last few years? It pretty much stays static?

Dr. COOPER. Yes.

Mr. MICHEL. But we look to a 40 percent improvement in the infant mortality rate since what, 1950? What do these other countries ahead of us show in improvement since those days?

Dr. COOPER. I do not have the absolute figures on each one.

Mr. MICHEL. If you would submit for the record anything meaningful there, I would appreciate it.

[The information follows:]

APPROXIMATE IMPROVEMENT RATE AMONG REPRESENTATIVE INFANT MORTALITY RATES: FOR SELECTED COUNTRIES 1966 AND 1973

[Rates are deaths under 1 year of age per 1 000 live births]

| Country | 1966 rate | 1973 rate | Percent improvement |
|---|---|---|---|
| Sweden | 13.3 | 9.6 | 28 |
| Finland | 17.6 | 10.1 | 49 |
| Norway | 16.4 | 11.3 | 32 |
| Netherlands | 14.4 | 11.6 | 20 |
| Japan | 18.5 | 11.7 | 37 |
| Switzerland | 17.8 | 12.8 | 29 |
| Denmark | 18.7 | 13.5 | 28 |
| France | 21.7 | 16.0 | 27 |
| German Democratic Republic | 23.2 | 16.0 | 32 |
| New Zealand | 17.7 | 16.2 | 9 |
| Australia | 18.2 | 16.7 | 9 |
| Canada | 23.6 | 16.8 | 29 |
| Belgium | 24.1 | 17.0 | 30 |
| United Kingdom | 19.6 | 17.5 | 11 |
| United States | 23.4 | 17.6 | 25 |

Dr. COOPER. There has been improvement worldwide as well. You are right when you point out that this percentage of improvement was not unique to the United States in this regard.

The improvements that we are seeing that result from better prenatal care, better nutrition in developing countries, and so on, are reflected in the advance of all countries in this matter of infant mortality.

Mr. MICHEL. You mentioned the big problem in our country of teenage pregnancies and I suppose it's a growing problem rather than a diminishing one, unfortunately. Is that same condition prevailing in these other countries ahead of us?

Dr. COOPER. In some, Mr. Michel. But I don't think it is as great a problem in most of the ones ahead of us as we are seeing now.

Mr. MICHEL. And then, too, I would probably be willing to wager that our statistical base, and our fact finding mechanism is much more sophisticated than probably other countries we are talking about, isn't it?

Dr. COOPER. Some of our associates in the Western World have very fine statistical systems. It is true that there is not necessarily uniform agreement on how some of the vital statistics are reported. This has caused some contention of a competitive sort about what the significance of various numbers is.

There is no question that in some instances what we are considering the data base and what they are considering the data base are different. Our figures are not corrected for that.

Mr. MICHEL. Do abortions come into this statistical thing in any way on the infant mortality rate?

Dr. COOPER. No, sir.

LIFE EXPECTANCY

Mr. MICHEL. All right. Now, with respect to life expectancy, we see a marked increase again. Here we have women now, white women, you say with an expectancy of 76.7 years as against white men at 68.9. But in the last 2 years an increase in women of 2.1 percent as against men at only 1.2 percent practically double in that short time.

How do you account for that?

Dr. COOPER. I wish I knew the answer to that, Mr. Michel. When I used to be at the Heart and Lung Institute I was always asked why it was that males had so many more heart attacks than females. In some age groups the difference is 3 to 1, and in other age groups it is 10 to 1.

What the actual difference is is very difficult to determine. I can't answer the question because I don't know what its biological basis or sociological basis is.

Perhaps some of my colleagues would take a flyer at it, but I don't know the answer.

Dr. SENCER. There was an interesting study done several years ago by the University of North Carolina, Mr. Michel, in which it tried to determine whether the increased longevity of women was inherently due to the fact that they were women. They tried to isolate out all of the cultural and stress factors. They took two groups: One of them were Catholic Brothers in a teaching order and the other was a group of Catholic Sisters in a teaching order and looked at their life expectancy, feeling they led quite similar environmental lives, and in that order the women did survive a longer time.

They thought that this was perhaps due to some selective dying off of women early in life from infectious disease and then they were able to survive better at the end.

Dr. COOPER. That is speculative.

Mr. MICHEL. I would be interested in some comparative studies with a selected group that would be, you know, somewhat different in composition than that to see whether there are some other physiological factors that might have a bearing upon longevity or shortening of the lifespan.

PUBLIC HEALTH SERVICE HOSPITALS

But, on the Public Health Service hospitals, now, I have been attempting over the years, to support what the Department wants to

do by phasing out of this area, and then the question was asked here, well, if we really want to maintain everything at the current level, et cetera, you would have to have $26 million more dollars. Now, that is just for operation and maintenance; is that correct?

Dr. VAN HOEK. That is correct.

Mr. MICHEL. It does not take into account some of these hospitals where you really have to do something substantial to bring them up to an acceptable standard. Is that correct?

Mr. MILLER. Excuse me, Mr. Michel. I would like a clarification. I thought that the additional money would be needed to bring us back to the 1973 level, but at the current level the budget is sufficient. We developed the budget on the basis that in 1977 we had enough money that if the hospitals were closed or transferred to provide for the contract care for the beneficiaries or maintain the current level of operation.

What is in question now is the fact that the law requires we maintain January 1973 level.

Dr. VAN HOEK. That is correct.

Dr. COOPER. I thought that was the question that was asked.

Dr. VAN HOEK. That was the question.

Mr. MILLER. I just compared the budget with current operations. The occupancy rate is lower now than in 1973.

### UNDERUTILIZATION OF PHS HOSPITALS

Mr. MICHEL. That was my next point: Was that if you say, well, whatever the current level or whatever it is expenditurewise, but then what is the occupancy rate at the specific hospitals? I have been given to understand in several that they are operating at far less than capacity and that that in turn is just an inefficient way of maintaining what is outmoded. Isn't that correct?

Dr. COOPER. The capacity is not 100 percent. It is down to about 67 or 69 percent overall, and I think that this has been the difference that Mr. Miller and Dr. van Hoek, and I think for the record just let me clarify what the distinction between the two questions was.

I thought the chairman asked us if there is enough money in the budget to meet what the 1973 requirement as opposed to the question that you asked.

Mr. FLOOD. That's right.

Dr. COOPER. That question and the question of whether there is enough money in the budget to meet the current level of operation are not necessarily the same. As you know, we can provide a certain operational base, but if we do not fill our capacity we do not operate at the same level.

The point that you are trying to make, I take it, is that with the decreasing capacity, is it an efficient way to operate the service?

### TRANSFER OF PROGRAMS TO THE STATES

Mr. MICHEL. And then I liken it to talking about oil and gas, and if you can use the pipeline with all of the capital costs, et cetera, and

if it's only used to 75 percent of the capacity, the cost of natural gas goes up, and it's kind of unrelated, but there is a similarity there of use of full capacity.

Now, you propose some major changes in Federal-State rules for health care. I would applaud you for not taking the approach of cutting down considerably in your budget request in anticipation of sure legislative enactment.

As I understand it, what you are proposing here is that while there are recommendations in the wings for change, you are still requesting what you feel is adequate to fund these programs until such change is enacted, and then I guess my followon question is, how do you make this transition with the kind of money you are testifying to here today?

Dr. COOPER. Since we were sensitive to the fact that there are some very important and ongoing programs our proposal is that the capacity would need to be maintained for a transition over at least a 3-year period.

The capacity and the specifications would so be written in the legislative proposal, so as to assure that no specific project could be reduced below 80 percent in the first year of operation, 50 and then 25 percent in the subsequent year. That doesn't mean that they would have to be funded at that level, but that the State would then have the option of funding it at 100 percent, 110 or any other number should they wish to maintain the specific activity that was previously supported by a direct Federal grant during that period of time.

POSITION REDUCTIONS RESULTING FROM BLOCK GRANTS

Mr. MICHEL. Now, what happens under the bloc grant to the staff of those health agencies? It is my understanding that this bloc grant approach, the savings that we would be realizing would be in reality Federal staffings, and what effect would there be here if we don't get the bloc grant approach enacted into law?

Dr. COOPER. We believe that as the program would become implemented there would be a reduction in required Federal staffing. There would be still some activities in all of these areas that would be required such as monitoring. That is provided for in the legislative proposal, but we expect there could be savings of 2450 positions in the Department's health programs.

Mr. MICHEL. And that would be over a period of what time?

Dr. COOPER. This reduction would take effect in the fiscal year in which the new law is enacted.

Mr. MICHEL. And what does that represent in dollar savings, roughly?

Dr. COOPER. Assuming an average salary of $15,000, the annual cost for these positions would be about $37 million.

BLOCK GRANT SAVINGS

Mr. MICHEL. Are there any other savings that we can point to specifically that come about as a result of going the bloc grant approach?

Dr. COOPER. Well, I think part of the idea that gave the impetus to this particular program was that the States and local jurisdictions

felt that they would, in addition, save a great deal of resources that they currently apply to responding to a multitude of separate categorical activities with different reporting systems, administrative requirements, and regulatory responses.

Mr. MICHEL. So really the sum of the figures I have heard publicized of savings that would be accomplished don't necessarily all represent Federal Government savings, but rather those which you predict or calculate as savings to local and State government as well?

Dr. COOPER. As you know, the total bloc grant concept had three portions. There was health, education, and social service. Now the figure I gave you on the 2,450 positions and some dollar savings in administrative costs would be related only to the health portion. And if it is, in fact, resulting in a reduced administrative cost in the local and State jurisdictions, then that would be added.

Mr. MICHEL. Now, there are several activities in the Public Health Service which do not as yet have an appropriation for fiscal year 1976 and we are still operating under the continuing resolution. Drug abuse, NIH training, health, manpower and some project grants.

In some instances it appears that there will not be a resolution of the legislative proposals before the end of the fiscal year.

How has this hiatus in the legislative process affected your ability to manage the program?

Dr. COOPER. Well, it is always more difficult to manage the program in the absence of authorizing legislation. We are always trying, aware that from time to time the Congress would want something done within a given time frame. Therefore, we try to wait the maximum period of time to give us the ability to implement the law within the fiscal year if that is the will of the Congress.

When a certain time is reached in the year, as now I would say, for example, in the manpower area, because of the complex nature of the review process and all of the other things that are required, the absence of the authorizing legislation almost makes it a requirement for us to do business in the old way within the same time frame for the current year in order to do it responsibly. So it does create certain problems for us, although we have to be prepared in two different directions. That increases our administrative costs because we must anticipate in both directions.

### NATIONAL HEALTH SERVICE CORPS

Mr. MICHEL. Now, when Dr. Edwards was the Assistant Secretary for Health, he told us that the national problem regarding availability of physicians was one largely of maldistribution. And this has been especially true in the rural areas, true in my area out in central Illinois.

Has the National Health Service scholarship program helped to resolve this problem?

Dr. COOPER. Yes. We think that the National Health Service scholarship program and the National Health Service Corps are among the finest programs that we have. I am delighted with them. I think the corps has received community acceptance, professional acceptance, and acceptance by the people in it themselves. The retention rate, people interested in staying longer than their prescribed

period of service, has increased tremendously, and I think it is a fine program, not because it only subsidizes some of the individuals but because it approaches for the first time, I think, the guts of the issue, which is preparing a local setting which has hospitality and working compatibility for the health professional. The community working together with the professional system has been the key to success here, and I think it is helping solve the problem.

Mr. MICHEL. Do I gather from your response that we are really not having a problem recruiting into the Public Health Service?

Dr. COOPER. We do not have a problem in recruiting at this time.

### GRANT PROGRAMS

Mr. MICHEL. Now, moving into the area of grants and contracts, about how many different grant programs are there under our auspices?

Dr. COOPER. The number of grant programs?

Mr. MICHEL. Why don't you just have that submitted?

The point I am driving at, of course, you have so doggoned many you would have to really ask yourself from day to day, you know, how many more do I have, and that would go for contracts, too, isn't that true?

Dr. COOPER. Yes, sir, we will give you the specific numbers. Some of them are both grant and contract. There are probably on the order, depending on how you define the program, of 175 different programs, most of which have some authority to make awards.

[The information follows:]

### NUMBER OF GRANT PROGRAMS

A total of 132 Public Health Service programs have been included in the Catalog of Federal Domestic Assistance. The following is a breakout of these programs by agency:

| | | | |
|---|---|---|---|
| ADAMHA | 25 | HSA | 16 |
| CDC | 5 | NIH | 61 |
| FDA | 1 | | |
| HRA | 24 | Total | 132 |

Mr. MICHEL. Yes; then give me the total dollar value of grants and contracts, too, will you please?

Mr. BERSANO. Total project grants are $3,953 million, and the project contracts are $661 million for 1976.

### REVIEW OF GRANT AND CONTRACT APPLICATIONS

Mr. MICHEL. Do you have a uniform procedure for approving and reviewing grants and contracts?

Dr. COOPER. Yes, sir, within the Public Health Service we have a guidance manual which is continually updated and made compatible with the general departmental guidelines.

Mr. MICHEL. Do they vary by program and agency?

Dr. COOPER. I think what varies about them is that the kind of application and the kind of review process that is required. Who does the review depends on the actual program. The actual milestones in the process, and the policy relating to what kinds of reviews, are all uniform.

Mr. MICHEL. And the general pattern for approval of grants and contracts, I guess, too, or is it by peer review?

Dr. COOPER. As mandated by the Congress, we are required to have peer review for grants and contracts. The peer review is a technical review, and then we also require a policy review as well as administrative practices review before grants are awarded.

Mr. MICHEL. And who decides on the makeup of these reviews or peer review groups?

Dr. COOPER. Well, the largest single group of peer review is in the biomedical research area. There is the Division of Research Grants at the National Institutes of Health, for example, which is the apparatus by which the Director of the National Institutes of Health administers the various review programs. He and his associates are responsible for the selection and the formation of those committees.

The administrators of the individual agencies have similar mechanism for review for their programs.

Mr. MICHEL. Is the decision of who should be on one of these groups made by a ballot of all eligible scientists in the field, by lot, or any other unbiased method, or is it really made by a relatively small group? Of what I might choose to call insiders.

Dr. COOPER. Well, it is not done by ballot, and it is not done by a general consensus vote of the scientists or any other group of specialists throughout the country. It is done without pejorative implication by a relatively small group of insiders.

Mr. MICHEL. Isn't it likely that members of an elite group of insiders naturally consider other members of their group or the institutions they come from to be better qualified than others and award their grants accordingly?

Dr. COOPER. No. I think the performance, the record will show, has been excellent. I cannot give you assurance that human nature doesn't exist in reviewers, Mr. Michel, but I think the record pretty well speaks for itself and my confidence in the objectivity of the people that give of their time for this has been great. Perhaps some of my other colleagues would want to speak to that. I think they have some very strong feelings on the soundness of the system. We think the amount of pettiness or bias in that sense is minimal.

Mr. MICHEL. What guidelines do these groups follow in selecting grant recipients? Do they set their own guidelines within the general parameters of the law or do they follow a rigid set of guidelines established by the Department?

Dr. COOPER. Well, there are certain kinds of guidelines set. For example, it is important that when the review is documented that we have evidence that certain specific things were taken into account. There is a process that governs the protocol, scientific merit, the objectives of the experiment, the qualifications of the reviewer, the quality or the presence or absence of facilities, the analysis of the budget, and the critique comments in general.

Now what does vary from time to time is that when you look at a scientific experiment of a certain kind. I am an expert in heart disease, for example. I do not check to see whether his electrocardiographic machine is of such and such a type, although I have to check to know whether this is the appropriate instrument for the experiment. So I can't write rules so specific that they eliminate the personal interpreta-

tion of the quality of the project itself. But as far as the areas that are supposed to be looked at, and documented in the review process, these are generally uniform and prescribed throughout the Department.

Mr. MICHEL. Now, is the public interest ever considerd in the process? In other words, are generally accepted standards of decency, morality. taken into account in the selection of a recipient or is it anything goes as long as it meets a certain scientific standard?

Dr. COOPER. No, sir. This has been the subject of considerable public debate for many years now. Even at our technical reviewer level, the reviewers and the staff are required to speak up on ethical issues and any other kinds of social policy issues that come to their attention in the review process. We do not believe that everything that is scientifically a curiosity is necessarily the right thing to support, or appropriate for the Federal Government to support.

In most of these programs there is a council. Most of them are statutory councils that have public representation besides scientific representation. These bodies are also required to specifically look at this kind of issue. In our manual instructions, if there are ethical questions involved, these are specifically highlighted for the consideration of the council members at the council meeting.

So there is attention to this. It still doesn't eliminate the responsibility of the Department, all the way up to the Secretary, if the issue raised for review is an appropriate ethical, moral, or social issue.

Mr. MICHEL. On that point, after a peer review group makes its decision, is it only in exceptional cases that it would have to be signed off by the Department?

Dr. COOPER. Yes, I think of the thousands of reviews that are done in this order, the usual delegation is considered appropriate. The issues are considered generally sound, and it is usually by exception that a specific case would be called for specific consideration or reconsideration by the agency chief or his counsel or the Department, the Assistant Secretary for Health, or the Secretary.

Mr. MICHEL. So, there are a number which could very well be onboard and going, one thing and another, without really Department heads knowing that they are, in fact, underway?

Dr. COOPER. You mean the Secretary?

Mr. MICHEL. Yes.

Dr. COOPER. The Secretary does not know of all of the projects that are going on.

Mr. MICHEL. And you suspect a few people under him?

Dr. COOPER. I do not know all of the projects although I do try to keep up with most of the programs.

### MARIHUANA—SEX STUDY

Mr. MICHEL. You know, there is one instance in which in my view public concern really wasn't taken into account, and that, of course, is that so-called sex-pot study down at Southern Illinois University.

Now that grant I understand is being reconsidered in your shop at the directive of the Secretary. Where does that reconsideration stand now?

Dr. COOPER. We expect to have the final meeting on this on March 11. We are requiring in the review not only the folks from the National Institute of Drug Abuse, but the Agency Chief, and the Commissioner of Food and Drugs, as well as my own participation.

The reason why it is, in part going to take so long is that Dr. DuPont is representing the United States at the moment in an important international drug control activity. Because of the importance of the questions raised by this study and the level of review asked by the Secretary, we felt that we should have all of the principals together to complete the review.

Mr. MICHEL. Well, I would agree with that. I was disturbed to hear the $61,735 of the grant was dispersed to Southern Illinois University 8 months ago, before immunity was obtained from the Justice Department so marihuana can be used in the research. Is it a standard procedure in the Public Health Service Division to disperse taxpayers' money for research that has not received a final approval in this case?

Dr. COOPER. No. The answer would be no, sir, we would not, as a practice, do this, but I don't think you should interpret what happened in that case as the issue that you raised. In other words, what was provided in the award was not permission to go forward, nor the clearance for the marihuana, but to do the preliminary parts that are necessary to execute the full project.

In the review I have already done, it was apparent to me that the kinds of preparation, validation of technology and so on was what was provided for in the initial award, but not the approval to go ahead with other parts of the experiment which have been the subject of the public policy discussion.

Mr. MICHEL. What really disturbs me is that, well, there is $18,707, I guess, by our last count, which already has been expended, yet no research has been conducted because immunity has not yet been granted.

But I suspect your response there to my earlier question may have cleared that up.

Dr. COOPER. Yes, sir. I think that you could take most projects that are 8 months old with a budget award of $60,000, and show no results within the 8-month period, because it is the time of gearing up and implementation.

Mr. MICHEL. Now, the grant proposal stated that the applicant checked out local opinion, and found no serious objection. On the other hand, we have received reports which show no indication that the community was ever contacted. As part of your review process do you ever seek to review such statements made in a grant proposal?

Dr. COOPER. Well, in this particular case you can be assured, Mr. Michel, we shall obviously do that. In response to the general notion, as you are probably aware, in human research requirements, the current regulations on human experimentation require documentation and periodic citizen review of the process and visitation of the persons that are there. Each and every application to an institution that does experimentation on humans is subject to these regulations and to this review. So we do check on this. It would be very serious if false information were being provided in the context of a clearance regarding social issues and ethical issues that we have intended to address by our regulations.

Mr. MICHEL. Well, I just want to say in wrapping up this part of my questioning on this thing, that how many times have I had to say over there on the floor of the House and I am not an academician and I am not a scientist and still each one of us on this side of the table have got to carry the ball down there under some very difficult circumstances.

I remember once specifically, $\$1/2$ billion for the National Science Foundation. Far be it from me to tell them how and what courses to pursue, and the same here. I am not equipped to tell you what avenues to pursue. But, I think we are at that point where if there is an area of doubt, as much as has been raised about this one, that maybe we should turn to the private sector, to a foundation. I don't say there is no valuable end to the research, maybe there is, but not with public funds, because the heat is just unbearable, and we have got to be the go-between, between you and those taxpayers behind us. And I guess my question is: Is there private foundation money available for research, you know, of this kind if we feel that it's just too critical and too sensitive a kind of thing to really be able to bare out here in public, and still be able to answer to the taxpaying public behind us?

Dr. COOPER. Let me say first of all, Mr. Michel, and I think I can be presumptuous enough to not only speak for my colleagues here but for the scientific community, that we really appreciate the translation process that the committee does, and we know how difficult that is in the scientific areas. I think it is also very fair to say that in this area of questions that often are the subject of public debate, irrespective of the scientific base of the grant, we are sensitive to the fact that most of the previous work was supported in the private sector. In recent testimony, for example, taken by the President's Panel on Biomedical Research, the Federal Government in particular was taken greatly to task because of its timidity and its lack of courage in dealing with this, because there are three levels of issues that we have to deal with.

I think that this is what makes it such a difficult problem. And I think as a culture we are just going to have to work our way toward gaining the continued confidence to work in these areas that are very difficult.

One issue is the scientific merit and the credibility of the people involved that are doing the work. We are comfortable with that process and have enjoyed great confidence for which we are grateful. The second is a less well understood public issue, and that is the medical appropriateness of some of these activities. Certainly in this day and age the space problems that we are having with marriages, divorce, crime, sex crimes, drug abuse, and I could go down the list, are tremendously costly. If we don't find some way to get some kind of information regarding these problems we will be setting ourselves back. Maybe our methods are somewhat primitive, as they were in certain other biomedical fields 25 years ago.

Third. Then comes the relationship of morality to public policy, and the transition between those last two issues is a very difficult step. Yet, I am very sensitive to the fact that the public is our patron, and that we have a tremendous job to do to retain its confidence and support. The private sector has taken the leadership in this area, and

has provided most of the support in the past for research and medicine in areas involving questions of public morality. I think this is an unusual situation. In the long run, it would probably be beneficial after a complete review, to lay out the pros and cons, providing that they are factual and not fraudulent. If the Congress were to so determine that this public policy review was inappropriate, for one reason or another, then we would, and the investigator would have to seek support for this kind of activity in the non-public sector.

Mr. MICHEL. Well, I just want to assure you folks I can fully understand in your Department, and those of you in the scientific, education community, that you then run up against a question of academic freedom at times. And I respect that. I am just saying if somebody has got to take the heat, then, you know, I would rather than to have you abort your own conscience in that regard, I will be willing to take the heat here and just become some old-fashioned prude, which I am not, frankly, in this area, and publicly say so, it's just that question for me, public money versus private money, and that is one that I have to resolve.

Dr. COOPER. We would want you to have the best information possible on which to make that decision.

Mr. MICHEL. I am sure of that.

Thank you very much.

Mr. FLOOD. Mr. Natcher?

Mr. NATCHER. Dr. Cooper, I want to thank you for an excellent statement and for you appearance before our committee, and to say to you quite frankly, Dr. Cooper, when I discuss with my people some of the problems that we have in Health, Education, and Welfare, I am delighted to know that you are serving in the capacity that you are serving in and I think you are doing a good job.

Dr. COOPER. Thank you, sir.

Mr. NATCHER. Dr. Cooper, further, you have a lot of good people around you, Dr. Cooper.

Dr. COOPER. First rate.

DIABETES

Mr. NATCHER. They are good people, and I think you are very fortunate.

Dr. Cooper, I want to return for just a moment now to the subject of diabetes and I am not going to rehash any of the questions that my chairman propounded to you. Yesterday in the House our colleague from Texas, Mr. Gonzales, under a special order, stated in part as follows, and I just want to read you just a portion of what he said:

> Mr. Speaker, I want to commend the National Commission on Diabetes for their excellent report to Congress on this serious disease. In order to carry out the Commission's long-range plan to combat diabetes, I am introducing a bill to insure that this plan is implemented. My bill established a National Diabetes Advisory Board, and any other actions which are needed to achieve the goal of preventing and curing diabetes, and its complications, and to improve the care and quality of life of those individuals who now have or who will get diabetes before preventive medicine or a cure is found.
>
> The bill that I am proposing also establishes a category of awards in the National Institute of Health as distinguished scientist awards to individual scientists who have shown continuous and outstanding productivity in research related to diabetes.

I won't read the rest of it, but I just happened to be present on the floor when Mr. Gonzalez made his statement under this special order.

I haven't examined his bill, Dr. Cooper, I don't know anything about the contents of his bill. Going back to diabetes for just a moment, Doctor, last year you told us that diabetes is a frequent traveler with arteriosclerosis associated with the problem of heart attack. Which of these diseases occurs first, the diabetes followed by arteriosclerosis and heart attack, or is it the other way around?

Dr. COOPER. I don't know the answer to your question, Mr. Natcher.

Mr. NATCHER. Take a crack at it, Dr. Cooper.

Dr. COOPER. I have metabolic disease experts with me. Dr. Frederickson, as you know, is very distinguished in lipodology and arteriosclerosis. I think I will take a crack at it, and then let him correct me.

Mr. NATCHER. Go ahead, Doctor.

Dr. COOPER. Basically, in the case of late onset of diabetes, the arteriosclerosis process probably was there first. In some other forms of diabetes, it was probably there first, and contributed to the development of the arteriosclerotic process or a vascular change in a different set of vessels under different circumstances with different organ preference. I don't think it's a simple answer. I think in some cases it was one way and in some the other.

Dr. FREDERICKSON. I think that is such a flexible answer I could concur in it.

Mr. NATCHER. Thank you, Doctor.

DIABETES AND HEART DISEASE

Mr. FLOOD. That's one time I knew what the witness was going to say.

Mr. NATCHER. Now Dr. Cooper, diabetes is an important risk factor in heart diseases. How do you as Assistant Secretary for Health assure yourself that diabetes research is given a high priority and sufficient funding by the Heart and Lung Institute?

Dr. COOPER. Well, as Assistant Secretary, I periodically review with the Director of the National Institutes of Health his program allocations. Particularly at the spring review, when we are preparing our budget request for the following years, we try to obtain an analysis of where the best opportunities are and what the performance of the programs has been.

I think it's no secret that for the past several years, dating back from the time when I myself was at the National Heart and Lung Institute, I was concerned that there was not enough attention being given to diabetes as a risk factor in heart disease, either by the Institute program which I was responsible for, or by some of the other programs for which we were coordinating activities at the National Institutes of Health. We have reviewed this situation and called together some experts in this regard. As a result of that, we made a commitment to try to increase our activity in this area.

We have the common ground of metabolism, but we also have the specific organ response that we have yet to try to deal with in a more specific way. And to be less obtuse, let me say that great progress has been made in diabetes in the control of blood sugar levels and prevention of acidosis and coma. This is an area of great accomplishment for which grant awards were made to Banning, Best and others.

Where we are not coming forth successfully perhaps, and it's reflected in the Commission report, is that the organ response, specifically say for the heart, seems to go on even though we are controlling the

blood sugar level. It has been alleged that controlled diabetes still has aggravating effects on the process of heart disease. So I think we have not found the key to understanding why diabetes, chemically controlled as we knew it for some years, was not decreasing the rate of heart attack.

Diabetes is a major cause of blindness, and although we have newer techniques now to deal with the treatement of some of the consequences of the diabetic retinopathy, we haven't really solved the riddle of why that complication occurs, even though the chemical diabetes is controlled. I think what we see in the Commission report is sort of an urgent appeal for increased activity by scientists concerned with the effect of diabetes on certain organs, rather than by just the metabolic scientists that have been concerned with the basis of the disease.

Now, I do not think this is an either/or situation. I think, indeed, if we learn about the total biological picture of diabetes in its various forms, we may understand the chicken and egg relation to arteriosclerosis and/or vascular change, and therefore be able to prevent it. In the meantime I do think there are opportunities for investigation of the effect of diabetes on various organs that we should consider specifically, whether it's in the brain or in the eye or in the heart or the kidney. I do understand the call for such activity in the Commission report.

The problem is, who's going to do it, and do we have specific proposals regarding how to do this yet? Now I think the Commission report will have the benefit of calling to the scientific communities' attention the need for work in this area. And then scientists who are cardiologists might direct their attention to that linkage and we will begin to get more applications. I view this as the way that the commitment to diabetes, in general, not only to arteriosclerosis in the Heart and Lung Institute, can be implemented successfully.

We cannot do this by just saying, here's more money. We have to have the ideas to do it.

Mr. NATCHER. Now Doctor, if you will, insert in the record the level of investment each Institute will make in diabetes research in fiscal year 1976 and 1977, and also include a brief paragraph stating what you believe each Institute's role is or should be insofar as diabetes research is concerned.

[The information follows:]

DIABETES AND RELATED RESEARCH AND TRAINING

[In thousands of dollars]

| | 1976 of 1977 President's budget | 1977 President's budget | Diabetes Commission, recommendations for 1977 |
|---|---|---|---|
| NIAMDD [1] | $18,392 | $19,625 | $32,909 |
| NEI | 4,896 | 5,415 | 8,207 |
| NINCDS | 1,546 | 1,732 | 1,792 |
| NIDR | 400 | 400 | 917 |
| NICHHD | 1,894 | 1,619 | 4,016 |
| NHLI | 7,000 | 6,000 | 7,450 |
| DRR | 5,687 | 6,324 | 6,750 |
| Other [2] | 2,053 | 2,053 | 2,053 |
| Total | 41,868 | 43,168 | 64,094 |

[1] Includes "related" from other program areas in addition to diabetes research.

[2] Diabetes research effort in institutes not directly affected by Commission recommendations (NCI, NIGMS, NIAID NIEHS) are estimated on the basis of the continuation of the 1975 level of support and are not specifically programed by these institutes.

## Institute Roles in Diabetes-Related Research

### National Institute of Arthritis, Metabolism, and Digestive Diseases

Diabetes research at the National Institutes of Health is centered in the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD). In addition to its intramural laboratory and clinical research in Bethesda, Md., the NIAMDD supports through its research grants program more than 150 different research projects related to diabetes at various nongovernmental institutions across the country. In addition to these projects directly or primarily concerned with diabetes, other research performed or supported by the Institute involves the disciplines of endocrinology and metabolism which are related closely to diabetes.

Institute research is focused principally upon efforts to find a cure or to identify a means of preventing the devastating long-term complications of diabetes. Approaches to the many problems of this complex metabolic disorder take many forms. For instance, there are structure-function studies in insulin and glucagon, studies of carbohydrate metabolism and lipid metabolism, studies of the mode of action, mechanism of release, secretion and biosynthesis of hormones and other metabolic products, and support of a selected number of diabetes-endocrinology centers. Other important research areas include epidemiological studies of the Pima Indians of Arizona, development of several new therapeutic approaches (now in the experimental stage in animals), and monthly publication of the Diabetes Literature Index.

The NIAMDD, principally through its Associate Director of Diabetes, Endocrine and Metabolic Diseases, will be the focus for coordination and implementation of the recommendations of the National Diabetes Commission.

### National Eye Institute

Because of the serious effects of diabetes on the eye, the National Eye Institute (NEI) places major emphasis on diabetes-related vision research. Investigations supported and conducted by the Institute are aimed at reducing the rate of blindness and visual disability from this disease. The NEI currently allocates 14 percent of its grants and contracts research budget to this effort by fostering laboratory and clinical investigations of diabetes-related eye problems and by supporting the development and evaluation of new treatement procedures. A major portion of this research is concerned with diabetic retinopathy, the most serious and common visual problem arising from diabetes and one of the leading causes of blindness in the United States.

### National Heart and Lung Institute

While the National Heart and Lung Institute (NHLI) does not have a direct programmatic focus on diabetes, it does support investigations which are diabetes-related. The metabolic effects and cardiovascular consequences of diabetes are studied as aspects of NHLI-supported investigations focused on atherosclerosis, hypertension, coronary heart disease, peripheral vessel disease, arrhythmias, heart failure, shock, and thrombosis in man and animals. In addition, epidemiological investigations of coronary heart disease include studies of diabetes as one of the several predisposing risk factors.

### National Institute of Child Health and Human Development

Most of the activities conducted by the National Institute of Child Health and Human Development (NICHD), with primary relevance to diabetes, deal with diabetes in pregnancy and the influence of this disorder on the mother, the fetus and the newborn, and with the influence of age on carbohydrate metabolism. In addition, NICHD conducts other projects which are somewhat less directly related to diabetes. Although the main focus of these projects is in other areas, some aspects of the research are relevant to the study of diabetes mellitus. Some of the topics of concern in these projects are as follows: metabolic and hormonal influences on carbohydrate metabolism in infants or diabetic mothers and low birth weight infants; pathophysiology of hypoglycemic disorders; and adipose tissue metabolism in obese, nonobese, and diabetic subjects.

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

The National Institute of General Medical Sciences (NIGMS) supports research in the basic or general biomedical sciences which have significance for two or more institutes. Research relevant to diabetes would therefore either be of a kind also relevant to other categorical interests and diseases, or serve as a type example illustrating or helpful in elucidating general biological principles. The Institute support in this area is exclusively extramural, through grants (including center grants) and contracts and is distributed among the five program areas: pharmacology-toxicology, clinical and physiological sciences, genetics, cellular and molecular basis of disease, and biomedical engineering.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) conducts and sponsors basic, clinical and applied research as well as research training, in the causes, prevention, diagnosis and treatment of toxic, metabolic, endocrine deficiency, cerebro-vascular, cardiovascular, and renovascular disorders which have direct bearing on understanding the underlying physiopathogenesis of diabetes and its complications in the central and peripheral nervous system.

NATIONAL INSTITUTE OF DENTAL RESEARCH

The National Institute of Dental Research (NIDR) is concerned with diseases that are specific to the oral cavity and systemic diseases that have manifestations in the mouth. The Institute is interested in diabetes mellitus, primarily in terms of its effect on the oral cavity. Diabetes is not one of the Institute's major areas of emphasis, but the etiology, pathogenesis, and clinical manifestations of this diseases are of interest to several of the major program areas within the Institute, including collagen research, the relationship between diabetes and periodontal disease, developmental biology and anomalies, caries, and diseases of the salivary gland and pancreas.

HEMOPHILIA AND BLOOD SEPARATION PROGRAM

Mr. NATCHER. Doctor, as you know, this committee included $3 million in the 1976 supplemental appropriation for hemophilia treatment and blood separation program. Now, some people told us that the blood factor required by hemophiliacs was not readily available and, therefore, we designated a substantial part of the funds for blood separation, as you will recall. However, we are getting conflicting signals now from other groups saying that we should have emphasized treatment. Doctor, what about this?

Dr. COOPER. Well, I was struck with the conflict itself, also, Mr. Natcher, very candidly. The advice I got on this was not clear when we tried to implement the recommendation immediately.

So I called for a clarification by the experts, and I do not think we should implement the fractionation activity until that review is completed, and I will be going to Mr. Miller and the Secretary, and back to you to suggest what we should emphasize with the funds available is hemophilia treatment while we resolve the question on the fractionation.

Mr. NATCHER. Thank you, Dr. Cooper.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Obey?

Mr. OBEY. Thank you, Mr. Chairman.

Dr. Cooper, we are all getting a lot of mail again on abortion. I wish I knew what the answer was, for a lot of reasons. But let me ask this, in conjunction with something else I want to ask on abortion: What is the total dollar amount being committed in this budget, this year for family planning? How does that compare with last year?

Dr. COOPER. The proposal in the President's budget is $79,435,000 and that is approximately a 20-percent decrease, from this year's level.

Mr. OBEY. Twenty percent what?

Dr. COOPER. Decrease.

Mr. MILLER. Mr. Obey, you need to remember—and we will be glad to provide a table—we spend a lot of money for family planning in both medicaid and title X.

[The information follows:]

VI

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
FAMILY PLANNING SERVICES

Obligations, FY 1973 -- FY 1977

| Agency and Program | Fiscal Year | | | | |
|---|---|---|---|---|---|
| | 1973 | 1974 | 1975 | 1976(Est.) | 1977(Est.) |
| Health Services Administration | | | | | |
| Bureau of Community Health Services (BCHS) | | | | | |
| Maternal and Child Health | 16,300,000 | 16,300,000 | 43,700,000 | 47,037,000 | 28,000,000 |
| Family Planning | 107,207,000 | 149,491,000 1/ | 99,826,000 2/ | 100,615,000 | 79,435,000 |
| Subtotal, BCHS | 123,507,000 | 165,791,000 | 143,526,000 | 147,652,000 | 107,435,000 |
| Indian Health Service | 896,000 | 1,061,000 | 1,237,000 | 1,347,000 | 1,476,000 |
| Bureau of Medical Services | 268,000 | 227,000 | 193,000 | 161,000 | --- 3/ |
| Subtotal, Health Services Administration | 124,671,000 | 167,079,000 | 144,956,000 | 149,160,000 | 108,911,000 |
| SOCIAL AND REHABILITATION SERVICE | | | | | |
| Social Services | 38,872,000 | 34,547,000 | 43,177,000 | 49,678,000 | 52,800,000 |
| Medical Assistance | 18,200,000 | 52,434,000 4/ | 56,772,000 | 65,512,000 | 74,625,000 |
| Total, Social and Rehabilitation Service | 57,072,000 | 86,981,000 | 99,949,000 | 115,190,000 | 127,425,000 |
| Total, HEW | 181,743,000 | 254,060,000 | 244,905,000 | 264,350,000 | 236,336,000 |

1/ Includes $15 million previously administered by the Office of Economic Opportunity; also includes $30 million authorized under the FY 1973 continuing resolution, released for obligation in FY 1974.
2/ Includes $409,000 authorized under the FY 1973 continuing resolution, obligated in FY 1975.
3/ This reflects the Drpartment's budget policy to close all Public Health Service General Hospitals and Outpatient Clinics in FY 1977.
4/ FY 1974 is the first year that actual expenditures for family planning were reported by the States. Obligations for years prior to FY 1974 are estimates.

Mr. OBEY. What I would like, if you want to give it to us, Charlie, and I don't have any special ax to grind, I just want to know what the total amount is in this entire budget for family planning, how it compares with our efforts the last 3 years.

Then let me ask you, Doctor, as a medical man to respond to this question. If you take the assumption that it's highly unlikely that a constitutional amendment on abortion would ever pass, what kind of things do you think we could do to discourage abortion in this country? I am not talking necessarily about legal prohibition but what other kinds of initiatives this society could make in order to reduce the tendency of persons to resort to abortion?

Dr. COOPER. I am not presenting the President's program here. The President has spoken, as you know, on abortion, and on the question of a constitutional amendment.

Mr. OBEY. Yes.

Dr. COOPER. And that's not the issue, but I think in the medical science there ought to be alternatives to abortion for a variety of purposes except for those where they are therapeutically necessary, and as the only option in the saving of life.

Now that does not preempt or in any way say that I am against the Supreme Court decision on that. My own private thinking on that is not the issue here.

The issue is that what is available, as you are asking the question, besides abortion for the variety of uses for which abortion may be made. Particularly I take it, you have in mind family planning as a tool.

Mr. OBEY. Well, I think that is only one device. I just wanted it to come from you rather than me.

Dr. COOPER. I was referring to family planning in the same sense I was talking about the teenage pregnancy question.

Mr. OBEY. Yes; that's why I brought it up.

Dr. COOPER. There need to be better educational processes not only for sex education, but better processes to deal with the question of wanted or unwanted pregnancy, and that means other forms of contraception, or family planning. It would depend on your religious bent or moral bent what kind of techniques are either suitable or unsuitable. In amplifying the rhythm approach we have increased our understanding of the biological manifestation of ovulation. There are techniques for this. Some of them are sophisticated and not appropriate and couldn't be accepted or used by all populations for all purposes.

For the teenage group it's clear that, in my opinion, I don't think every teenager ought to be taking pills for a wide variety of reasons, some of which are my own professional moral biases and societal biases and religious biases, and so on.

But the fact of the matter is that this issue comes about because a teenage pregnancy is often the result of a casual relationship. There needs to be a better understanding of what teenagers can do to prevent that and how to accomplish it, what the social and economic and cultural costs of the pregnancy might be and so on.

Dr. Hellman is responsible for this within our program. I don't think he is with us this morning, but we could provide you with a copy of the kinds of alternatives that now exist. Now, abortions, as you point out, are used for other things beside just family planning or dealing with teenage pregnancy, and in some cases there is no question——

Mr. OBEY. I would like to have for the record a comprehensive statement from you or somebody else on not only what is available, but what ought to be available.

Dr. COOPER. Yes, we will provide that information. There is a spectrum which I think ought to be available in any case to the population who may select out one technique or another.

[The information follows:]

ABORTION STATISTICS

United States (legal)

| Years | Number |
|---|---|
| 1970 | 193,500 |
| 1971 | 485,800 |
| 1972 | 586,800 |
| 1973 | 745,400 |
| 1974 & 1975 | Not available |

World (legal)

Abortion is practiced worldwide. Data from selected countries are shown in the attached table.

The situation in mid 1975 can be summarized as follows:

Thirty million pregnancies are estimated to be terminated annually by abortion throughout the world. The figure is a guess. More precise data indicate about 8 percent of the world's population live in countries where abortion is prohibited without exception and 15 percent in countries where abortion is permitted only to save the life of the pregnant woman. About 12 percent live under statutes authorizing abortion on broader medical grounds, that is, to avert a threat to the woman's health, rather than to her life, and sometimes on eugenic and/or juridical grounds (rape, etc.) as well. Countries where social factors may be taken into consideration to justify termination of pregnancy account for 22 percent of the world's population and those allowing elective abortion for at least some categories of women, for 36 percent. No information is available for the remaining 6 percent; it would appear, however, that most of these people live in areas with restrictive abortion laws.

The abortion statutes of many countries are not strictly enforced and some abortions on medical grounds are probably tolerated in most places. It is well known that in some countries with very restrictive laws, abortions can be obtained from physicians openly and without interference from the authorities. Conversely, legal authorization of elective abortion does not guarantee that abortion on request is actually available to all women who may want their pregnancies terminated. Lack of medical personnel and facilities or conservative attitudes among physicians and hospital administrators may effectively curtail access to abortion, especially for economically or socially deprived women.

Restrictive Laws

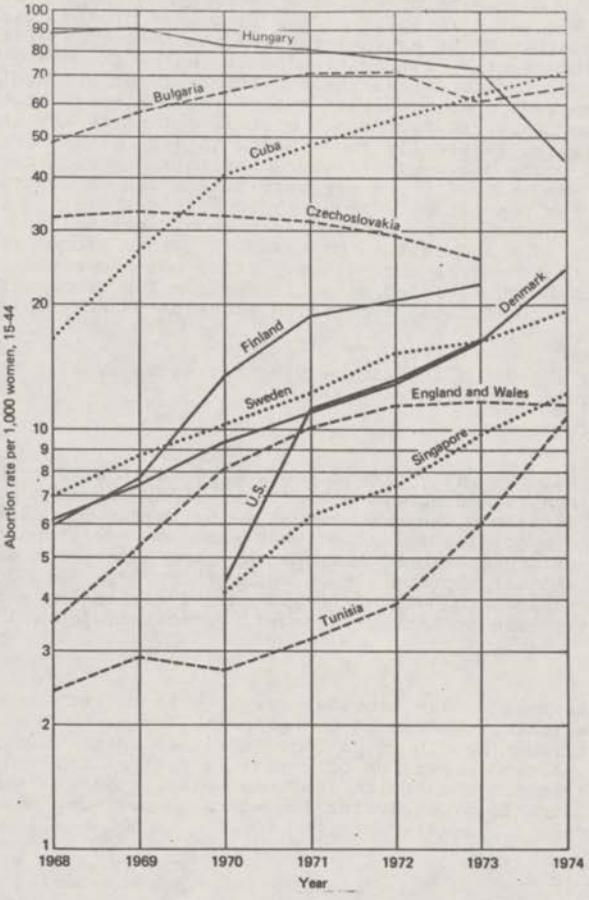
Restrictive laws suddenly imposed as in certain countries of Eastern Europe reduce the incidence of abortion and increase the birth rate. This effect is short-lived. Illegal abortion apparently becomes rapidly available especially in major cities.

United States (illegal)

An estimate made in 1957 stated that "A plausible estimate of the frequency -- could be as low as 200,000 and as high as 1,200,000 per year." There is no plausible basis for selection of any figure.

The results of a retrospective survey in New York City and a randomized survey in North Carolina, however, are compatible with the usual estimate of 1,000,000 illegal abortions a year. Judging from the marked reduction in morbidity, the number has been drastically reduced since 1969-70.

Legal abortions per 1,000 women aged 15-44: Selected countries, 1968-74 (Semilog scale)



## ALTERNATIVES TO ABORTION

The data available reveal no completely or even moderately successful alternatives to abortion. Given the tremendous sexual drives of the human race and the fallibility of contraceptives--the practice of abortion cannot be eliminated.

Two alternatives to abortion, prevention of pregnancy and support of women with illegitimate pregnancies, have been attempted with varying degrees of success. In spite of the fact that middle class American women use contraception extensively and that nearly 5 million women with low incomes, 1.2 million of whom are below the age of 20, are given contraception services through federally or privately financed programs, the number of out-of-wedlock pregnancies and abortions continues to increase. Most important is the increase among teenagers, especially those below the age of 17. Pregnancies among these young girls exact severe health and social problems for both mother and baby. There are barriers to use of contraceptives in the teenage population. Among these barriers are the inadequacy of current contraceptive techniques, personal beliefs and group mores, State laws and failure of males to assume proper responsibility for their sexual activities. It is not known whether an intensive campaign directed at contraception for teenagers would be effective. Further, such a campaign might be unacceptable to our people.

Programs to support illegitimate pregnant girls usually have the three following major components:

### Education

This component generally provides education that will keep girls up with their nonpregnant peers so that pregnancy or motherhood does not remove them from the educational mainstream. The education unit includes the special information they need to understand the physiological and emotional changes they are undergoing due to pregnancy, and helps prepare them for motherhood. This component is also structured to help girls who may have changing educational requirements, such as a need to acquire practical job skills.

### Health

This component generally provides services to correct or alleviate existing medical problems and promotes the future health of mother and child through health education, nutrition instruction, immunizations, and provision of prenatal, postpartum, and pediatric medical services. The health component also provides family-planning instruction, including long-term support for the use of such services.

### Social Services

The social service component generally provides counseling and other services to help girls solve the problems that either may have led to or been caused by the pregnancy. It provides the links between the program, the family, and the related community services and resources.

These components, as has been mentioned, can be combined with any number of other components to see that the needs of young families are well met.

In addition, the following list of services should constitute an ideal program.

Accredited Education
Vocational Counseling
Vocational Training
Vocational Placement
Abortion Counseling
Prenatal Care
Postpartum Care
Interconceptional Care
Birth Control
Pediatric Care
Health Education
Continued Casework
Psychiatric Treatment
Psychological Testing
Group Counseling
Legal Counseling
Legal Services
Adoption Counseling
Adoption Services
Leisure Time Activities
Living Facility During Pregnancy
Living Facility After Childbirth
Financial Assistance
Services to Baby's Father
Services to Girl's Family
Services to Baby's Father's Family
Training in Child Development and Child Care
Care of Infant

The Office of Education has identified over 600 local programs which provide some assistance to pregnant teenagers. An estimated 300 programs provide comprehensive services. Evaluations of several of the most comprehensive programs demonstrate their short-term effectiveness in improving the health status of the woman and infant and in decreasing the incidence of school dropouts and repeat pregnancies. Their long-term effectiveness is not so clear. After the women leave a program but while they are still teenagers, a large number experience repeated pregnancies, drop out of school and do not attain economic independence.

In short, given our present state of knowledge and magnitude of effort, neither prevention nor support of pregnancy give adequate alternatives to abortion. Expanded biomedical research for improved contraceptives and increased behavioral research on teenage motivation are urgently needed.

Mr. OBEY. Let me ask, the first response is, if we emphasize more family planning we ought to have less of a problem with abortion and I hope that is true. But what about encouraging people to use family planning devices, contraceptives, the pill, et cetera, in light of all of the headlines you see in the newspapers about the risk involved? Where do you come down as a medical man on that?

Dr. COOPER. The statistics are coming out on a wide variety of techniques. I think the risk in abortion, for example, depends on the circumstances in which the abortion is done. It ranges all the way from doing an abortion for a ruptured tubal pregnancy which has a high risk, all the way down to some of the techniques which are done on almost an ambulatory basis, that when done properly, have a low incidence of complication.

Things like the pill, the IUD, and all of these other types of techniques all have some small risk, as we know the technology and its impact right now. They are not of different orders of magnitude in my opinion. The techniques like the condom and so on do not have a high incidence of complication, of the same type, such as causing other medical diseases or having the potential for a serious accident like the rupture of the uterus or the puncture of the uterus by inappropriate techniques during an abortion.

So I think there are safety differences depending on the scope of techniques that you want to deal with.

Mr. OBEY. Again, would you just for the record supply something sort of summary of what the situation is?

Dr. COOPER. We will summarize that and show what the current feelings on risk are. These have recently been written about frequently. We have data on the pill, data on the IUD, and data on abortions themselves as properly done.

[The information follows:]

RISK OF MORTALITY ASSOCIATED WITH DIFFERENT METHODS OF CONTROL OF FERTILITY

Serious health risks which are associated with the use of various methods of family planning and result in deaths are small. An evaluation of these risks associated with a particular method of contraception will need to consider not only the deaths related to the use of the method itself and therefore attributable to it but also the deaths due to pregnancies which may result because of method failure. Also, risks vary by the age of the woman and by her socioeconomic status. A recently conducted study provides comprehensive information on this subject.[1/] Key findings of this report are summarized in table 3 from this article and are discussed below.

**Table 3. Annual number of live births, induced abortions and deaths associated with control of fertility, per 100,000 women, by regimen of control and age of woman**

| Regimen of control and outcome | Age group | | | | | |
|---|---|---|---|---|---|---|
| | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 |
| **A. No control** | | | | | | |
| Live births | 49,750 | 59,260 | 54,290 | 49,160 | 37,810 | 18,250 |
| Birth-associated deaths | 5.3 | 5.0 | 6.6 | 12.3 | 15.5 | 12.6 |
| **B. Abortion only** | | | | | | |
| Induced abortions | 96,520 | 128,470 | 121,770 | 108,220 | 85,720 | 37,690 |
| Abortion-associated deaths | 2.2 | 2.4 | 2.3 | 4.5 | 7.9 | 3.8 |
| **C. Oral contraception, no abortion** | | | | | | |
| Live births | 1,120 | 1,870 | 1,770 | 1,560 | 1,090 | 380 |
| Birth-associated deaths | 0.1 | 0.2 | 0.2 | 0.4 | 0.4 | 0.3 |
| Method-associated deaths | 1.3 | 1.3 | 1.3 | 4.8 | 6.9 | 24.5 |
| Total deaths | 1.4 | 1.5 | 1.5 | 5.2 | 7.3 | 24.8 |
| **D. IUD, no abortion** | | | | | | |
| Live births | 1,120 | 1,870 | 1,770 | 1,560 | 1,090 | 380 |
| Birth-associated deaths | 0.1 | 0.2 | 0.2 | 0.4 | 0.4 | 0.3 |
| Method-associated deaths | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Total deaths | 1.1 | 1.2 | 1.2 | 1.4 | 1.4 | 1.3 |
| **E. Traditional contraception, no abortion** | | | | | | |
| Live births | 9,950 | 15,490 | 14,520 | 12,880 | 9,190 | 3,430 |
| Birth-associated deaths | 1.1 | 1.3 | 1.8 | 3.2 | 3.8 | 2.4 |
| **F. Traditional contraception and abortion** | | | | | | |
| Induced abortions | 13,310 | 19,860 | 18,820 | 17,300 | 12,550 | 4,900 |
| Abortion-associated deaths | 0.3 | 0.4 | 0.4 | 0.7 | 1.2 | 0.5 |
| Deaths due to motor vehicle accidents | 23.6 | 19.0 | 13.0 | 12.4 | 11.8 | 12.4 |

From Family Planning Perspectives, Vol. 8, No. 1, Jan, Feb., 1976.

1/ Mortality Associated with the Control of Fertility, Tietze, C., Bongaarts, J., and Schearer, B Family Planning Perspectives, Vol. 8, No. 1, Jan. Feb., 1976.

Oral contraceptives have an effectiveness of about 99% and therefore the number of pregnancies coming about because of method failure are exceedingly small. Therefore, the mortality risk associated with oral contraceptives is almost exclusively due to the method itself This ranges from a low of 1.4 per 100,000 women aged 15 to 19 to a high of 24.8 among women 40-44 years of age.

Intrauterine devices likewise have an effectiveness of close to 99%. Therefore, deaths are solely attributable to the method itself. The estimated mortality rate is lowest in women 15-19 years of age at 1.1 per 100.000 women per year and increases slightly to a high of 1.4 in women 35-39 years of age.

Traditional methods of birth control like the condom and diaphram have an effectiveness of approximately 90%. There is no known mortality associated directly with these methods. The mortality is solely due to pregnancies which come about because of method failure. Among 100,000 women who use traditional methods of contraception for a period of one year the birth associated death rate ranged from a low of about 1.1 for women aged 15-19 to a high of 3.8 among women 35-39 years of age.

If 100,000 women were to use traditional methods of contraception and resort to induced abortions for pregnancies coming about as a result of method failure, the mortality would be solely due to abortion. This would range from a low of .3 per 100,000 women aged 15-19 to a high of 1.2 in the age group 35-39.

If 100,000 women for a period of one year were to use no method of contraception but resort to abortion only for pregnancies occurring during this year we deal then with the mortality associated with induced abortions.

This would range from a low of 2.2 for the age group 15-19 to a high of 7.9 for women 35-39 years of age.

Finally, if 100,000 women were to practice no contraception and would not resort to abortions the mortality would be solely attributable to pregnancy and child birth. Such a mortality would be lowest in the age group 20-24 years of age at 5 per 100,000 women and increase to a high of 15.5 for the age group 35-39 years of age.

Clearly the risk is highest for women age 40-44 who are using oral contraceptives as their method of birth control.

Limiting such an evaluation solely to mortality will obviously miss important aspects of morbidity which may be associated with particular methods of contraception. In this context it is particularly important to note that the estimated rate of hospitalizations related to intrauterine devices appears to be higher than that attributable to oral contraceptives. 2/

The rate of hospitalization related to intrauterine devices is estimated to range from 3 to 10 per 100,000 women years of IUD use whereas the rate of hospitalization attributable to combination oral contraceptives is estimated to be about 1 per 1,000 women years.

In summary while the serious risks associated with available methods of contraception are low and indeed lower for the most part than mortality risks associated with pregnancy and child birth, the widespread use of these methods results in an appreciable number of deaths among its users. Undoubtedly safer, effective methods would be most desirable.

2/ IUD Related Hospitalizations, United States and Puerto Rico 1973. Kahn, H S., Tyler, C.W., JAMA, Oct 6, 1975, Vol 234 No. 1.

MORTALITY AND ALCOHOL

Mr. OBEY. Let me ask you just a couple of general questions on your statement. On page 5 you mention that "Males who drink heavily at least four times a week have death rates four times higher than do other drinkers." As a fellow who likes a few occasionally, why don't you tell me what you define as heavy drinking? For the record, I come from Wisconsin which as I understand it consumes 37 percent of the Nation's brandy.

Dr. COOPER. Well, in response to your question, there have been different definitions by the experts in this field. Frequent heavy drinking usually is a category that includes five or more drinks in a day. And then, you have to look at the mortality against the amount per day and how many days a week that amount is consumed. As you know, some people are drinkers on weekends or only certain days of the week.

Mr. FLOOD. You don't include beer in that?

Dr. COOPER. I include anything. The net intake of alcohol. Persons who drink at least four times a week as a heavy drinker, have a mortality rate say of 4.5 times that of an abstainer.

FEDERAL ASSISTANCE FOR HEALTH ACT

Mr. OBEY. On page 6 of your statement you say, "As you know, there are two major legislative proposals to be submitted by the President in the coming months which will have a significant bearing upon the budget request for fiscal year 1977" and then you go on to talk about the consolidating of the programs and et cetera. You say in the coming months. What is the timetable on that?

Dr. COOPER. The Department anticipates that the legislation on the Federal Assistance for Health Care Act, the block grant will be submitted to the Congress the latter part of next week.

Mr. MILLER. Tuesday.

Dr. COOPER. February 26 or 27.

Regarding the Public Health Service hospitals, our target date, as I mentioned to the chairman earlier, was about April 1. I cannot guarantee that we will make that, because, although our work on the specifics of the proposal would be completed and prepared, by law we are not able to submit legislation until the "B" and "A" agency review is completed.

Mr. OBEY. Well, let me just make a comment. We have this new budget process which I think most people on both side of the aisle are trying to live up to in the Congress. That budget process has some deadlines which are spelled out and it implies others, and it just seems to me that it really does a disservice to the public understanding of how the whole budget system works in this country when we suggest that these bills to be submitted next week, could be considered in sufficient time to include them in the budget plans for this year. I think the President has a perfect right to suggest that it will have a budget impact down the road, but I certainly don't believe that this kind of a timing problem indicates any real intent to include those items in determining what our budget decision ought to be this year.

RESEARCH EMPHASIS

Doctor, let me say usually I am disagreeing with thing's that the administration has done in this budget. Let me suggest while I don't agree with some of the specifics, and, in fact, I have some strong disagreement with some of them, that at least I agree with the general thrust in one area that you show in this budget. In the last five years we have more than tripled the amount of money available for the Cancer Institute which is more than a half-billion dollar increase in their annual budget. But, other institutes such as General Medical Sciences literally didn't get enough to keep up with the cost of inflation, so there is really less research going on there than before. This year you are requesting we cut NCI by $75 million and redistribute the cuts to other Institutes.

Dr. COOPER. Yes.

Mr. OBEY. Would you expand on your reasons for doing that? Do you think you could get better quality research by spreading that money around? What are your reasons for doing that?

Dr. COOPER. The main reason is that I face limited resource figures that I could recommended an allocation within. I look at the scientific opportunities and the case for progress and the total impact on health. I look at the turnover potential for grants that are completed, what their impact on the level of activity might be, and I want to consider areas where we have not taken advantage recently of some new opportunities. I also want to consider recommendations from other advisers and recommendations from the scientific agencies.

For example, I think the notion in this country that infectious disease is controlled is overdone. It isn't. I think the problem of influenza is very much with us.

Mr. FLOOD Today.

Dr. COOPER. Today, yes, sir.

Mr. FLOOD. I mean this afternoon.

Dr. COOPER. It is likely to be a problem in the near future of perhaps greater need. We don't usually think of that in the same thought pattern as cancer, but I think it's an important economic and health issue that takes away cancer patients, heart disease patients and the like. Hepatitis, gastroenteritis, and some of the diabetes questions are other areas of good opportunities that are very important to address. When I see the question of where I could recommend that we have a holding pattern for the next phase, I think I had to make the hard decision in the cancer budget and in the heart budget, as you see. Since they have had recent infusions of money, they should be able to make the adjustments as the others have in the short run, if that's what the total resources available are.

That is not to say that I don't think there are other opportunities in other areas of cancer or heart disease.

Mr. OBEY. Is it at all possible that the breakthroughs we are all hoping for in cancer research might well come from medical information gained from activity in other Institutes.

Dr. COOPER. I think the record shows, Mr. Obey, exactly that. Any disease breakthrough, so-called, that usually comes over a period of time, is a creation of findings of scientists from a broad range of disciplines. I would expect even now a great deal of contribution to the progress in the cancer program to come from people supported by the National Institute of Allergy and Infectious Disease, from the National Institute of Environmental Health Sciences, from the National Institute of General Medical Sciences and from other agencies, so I think that the total national cancer effort is not only in that one budget.

Mr. OBEY. If I could interrupt at that point, could you just supply for the record some examples of what you are talking about?

Dr. COOPER. Surely.

[The information follows:]

The progress that is made against any given disease or group of diseases is generally derived from fundamental research efforts which deal broadly with a wide array of normal and abnormal life processes. Thus the research conducted or supported by a given institute of the NIH may have relevance not only to its range of categorical disease interests, but also to the more diverse categorical interests of other institutes.

To illustrate, the National Institute of Allergy and Infectious Diseases has very specific intramural and extramural activities relating to viral diseases and immunological phenomena. This work is of great potential importance to the National Cancer Institute because of the very strong likelihood that one or more viruses may play a definite role in the causation of one or more forms of human cancer. Any work that serves to shed light on the properties of viral disease may be of value in defining the relation of viruses to cancer.

The same may be said of immunology, that broad area of science that deals with the body's ability to resist disease. Great alterations in the body's immune defense mechanisms are often seen in cancer as well as in many other diseases. Any information which helps us to understand why and how these changes occur, and how such changes may be modified, may be of potential value in preventing, diagnosing, or treating any number of diseases.

The interests of the National Cancer Institute and the National Institute of Environmental Health Sciences are also closely interwoven inasmuch as both Institutes have interests in environmental insults which can result in cancer and a variety of other diseases in human populations. Thus the information developed by the National Institute of Environmental Health Sciences in respect to the toxic properties of certain chemicals may have a direct relationship to their potentials for causing cancer.

The National Institute of General Medical Sciences supports a range of research efforts that relate broadly to the restricted categorical mission of all the other institutes. That institute has specific programs which include genetics, molecular biology, cellular biology, pharmacology and toxicology. These are areas which underlie and relate to all diseases and therefore the work supported represents a pool of information which may prove to be important in designing programs to deal with specific diseases.

Thus work of potential importance to the national cancer program is being carried on throughout the National Institutes of Health. It is the responsibility of the National Cancer Institute to identify and analyze this work and bring the relevant information to bear on specific cancer programs in a timely and appropriate fashion. In a similar way, much of the work supported and conducted by the National Cancer Institute has great potential relevance to the categorical disease problems of concern to other institutes.

## CANCER RESEARCH

Mr. OBEY. What was the budget request for the Institute submitted by the Institute, NCI?

Dr. COOPER. It's a considerable number; $948 million.

Mr. OBEY. They requested $948 million and the figure in this budget is what?

Dr. COOPER. $688 million.

Mr. OBEY. Where was that cut made, at NIH or by you or by OMB?

Dr. COOPER. As you know, the cancer authorization specifies that its budget goes directly to OMB. The Director of NIH and the Assistant Secretary or the Secretary usually are asked to comment on the budget, but not to change the budget. So that the essential decision that was made in this budget came from the Office of Management and Budget. There were different recommendations than those of us who reviewed it made.

Mr. OBEY. What were your recommendations?

Dr. COOPER. The estimate from the National Institutes of Health from their evaluation was $744 million. Ours was $688 million. The Secretary accepted ours for forwarding to OMB, and OMB allowed $688 million within the total package that it recommended for research.

Mr. OBEY. Well, both of the last two people who have held your job have written my office concerning the way we have been funding the cancer program, and, Mr. Chairman, I would like to insert in the record, if I could at this point, these two letters.

Mr. FLOOD. Without objection.

[The letters follow:]

BECTON, DICKINSON AND CO.,
*Rutherford, N.J., October 28, 1975.*

Hon. DAVID R. OBEY,
*House of Representatives,*
*Washington, D.C.*

DEAR CONGRESSMAN OBEY: This note is in response to the question posed by members of your staff regarding my views on the National Cancer Institute's budget.

I am strongly opposed to this budget for several reasons. First and foremost, I am convinced that we do not have the manpower resources in the United States to effectively spend $700 million. As a result, we are spending large sums of money on mediocre or less research. At some point in time, the cancer lobby must recognize that there is a limit to Federal expenditures for cancer research.

Another factor that must be considered in developing the National Cancer Institute's budget is the imbalance this creates at the National Institutes of Health. It is important that we not create an environment at the National Institutes of Health where we have "have" and "have not" institutes. In the case of cancer research, it is certainly conceivable that knowledge relating to cause and cure for cancer may be developed in one of the other NIH institutes.

This is, indeed, a very complex issue that has been made more complex by the Congress each year adding more and more to the cancer budget. Eventually, this budgetary matter must be looked at as a cost benefit issue.

As I have indicated, this is a complex subject and because of the tremendous impact that it will have and will continue to have on the entire biomedical research community, it needs to be carefully reviewed.

If I can be of any assistance, please feel free to call on me.

Very sincerely,

C. C. EDWARDS, M.D.

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THE UNIVERSITY OF ARIZONA,
ARIZONA MEDICAL CENTER,
*Tucson, Ariz., October 20, 1975.*

Hon. DAVID R. OBEY,
*c/o House Appropriations Committee,*
*Washington, D.C.*

DEAR MR. OBEY: A member of your staff has recently contacted me to ascertain my reaction to the current situation respecting the proposed appropriation to the National Cancer Institute, and I am glad to submit my reaction to you should you find it useful.

When the National Cancer Act passed I was, personally, in opposition to it although, because I was serving as Assistant Secretary for Health in the Department of Health, Education, and Welfare at that time; and because the administration supported the act, I obviously testified on its behalf. My opposition was based on the fact that the objective that the Congress and the administration wished to achieve could be achieved by appropriate funding and specific authorization to the existing National Cancer Institute within the National Institutes of Health. I opposed setting the National Cancer Institute "apart" such that it could report directly to the Office of Management and Budget. I still hold that conviction.

One cannot deny, at the same time, that the National Cancer Institute has achieved greater visibility, strength, and higher appropriations, as a consequence of what followed the passage of the National Cancer Act; but prior to leaving Federal Service, I indicated my strong concern to the Office of Management and Budget that the appropriation levels being sought for the support of the National Cancer Institute were becoming disproportionate to the other Institutes of the National Institutes of Health, and I remain convinced, today, that this has not only been true but is becoming increasingly true. I am, like you I am sure, interested in identifying and achieving an appropriate level of support for the National Cancer Institute, but I remain convinced that this should not be done at the expense of achieving an equally appropriate level of support for the other Institutes of the National Institutes of Health. My basic reason for holding this view is that advances in cancer research do not, by any means, necessarily come through research done for and on behalf of the National Cancer Institute but may well come out of the National Institute of General Medical Sciences, the National Institute of Arthritis and Metabolic Diseases, and so forth.

The basic justification for the high appropriations to the National Cancer Act is that the authority embraces service elements in the field—a responsibility that, for the most part, has been foreign to the background of the National Institutes of Health. I would suggest that a better formulation of the problem would be to fund the basic research that is necessary to attack the problem of cancer through the National Cancer Institute and let the patient service elements (sometimes called "control" programs) reside in other agencies of DHEW.

Again, my justification for holding this view is that by including the control programs in the appropriation to the National Cancer Institute, one tends to overappropriate to cancer, credit it to research, and thereby (since resources are limited) reduce the research funds available to the other Institutes. This, in other words, becomes counterproductive and may ultimately defeat the purpose of the original legislation.

Whether or not these comments are helpful I would not be certain, but you are more welcome to them, and to use them in any way that you choose.

Very sincerely yours,

MERLIN K. DUVAL, M.D.

Mr. OBEY. I would like to read something from one of them, from Dr. Edwards who said:

First and foremost, I am convinced we do not have the manpower resources in the United States to effectively spend $700 million on cancer research. As a result, we are spending large sums of money on mediocre or less research. At some point in time, the cancer lobby must recognize that there is a limit to Federal expenditures for cancer research.

Another factor that must be considered in developing the National Cancer Institute's budget is the imbalance this creates at NIH. It is important that we not create an environment at the National Institutes of Health where there are have and have-not Institutes.

Are you in agreement with your two predecessors on that point?

Dr. COOPER. Well, I am not in agreement with all of the reasoning that comes out to the same answer about how you deal with the allocation of the resources. You see, I think within that cancer program, in my opinion, some of those activities are in different kinds of categories.

You have the so-called control activities which are one kind of activity. When you lump them together and say that some of this is research, I think you do a bad comparison to the actual research. There are other kinds of research activities, both clinical research and laboratory research, that go on in the programs, and that's not a small part of that budget. So I think that when Dr. Edwards says there isn't manpower to do $700 million worth of research, now, I think, his breakdown of what he is talking about there becomes important.

I think the cancer team itself and the cancer board have recommended that we anticipate the need for manpower, and support the development of that manpower, and that's within that cancer authorization also. So I don't think it's a lack of awareness by the Cancer Institute, if I could speak on their behalf, of the need to have a balance between available manpower and these activities.

That National Cancer Institute budget is a large composite in that sense. I do not equate my option of rebalancing some of the opportunities to saying that the opportunities in cancer are all mediocre. You always have to make a choice and list things, and I listed some of the things in cancer at a lower priority in my estimation than some of the scientific opportunities in the other areas which I think are of great importance to the overall national health program. So I wouldn't say it exactly like Dr. Edwards says it.

Mr. OBEY. What I just want to get on the record clearly on this point is the answer to this question.

If I am to explain and in some way defend the decision on this point, I have to know that the reduction in the cancer budget just doesn't represent good old Republican philosophy of holding down spending, and that it really is the feeling of most of the professionals, most of he career professionals that serve with you that that is in fact a good medical judgment.

Dr. COOPER. Well, I think perhaps Dr. Fredrickson, who has both a great interest and a great stake in that resource allocation, might comment in response to giving you some assurance on the question of balance and allocation within any given dollar level.

Dr. FREDRICKSON. Mr. Obey, the budget request for NIH was prepared prior to the passage of the 1976 appropriation over the President's veto last month.

But nevertheless, it is true, as Dr. Cooper says, that this year's budget makes a very conscious effort to maintain capabilities and pursue certain opportunities in the overall biomedical effort, some of which had slipped in their support over preceding years. We take note of one particular point, and that is that in 1971 funds for the Cancer Institute represented 14 percent of the total biomedical support research efforts supported by NIH. Last year that figure became 33 percent and that figure that you now see for the Cancer Institute still represents 32 percent of the total NIH appropriation.

I should add that the budget figure for Cancer should also include a substantial share of the separate amount budgeted for the construction of the ambulatory care research facility. All of the Institutes have contributed to this but Cancer contributed the largest share because it will be of great assistance to that Institute in carrying out its mission.

Mr. OBEY. Let me just say I am not certain I agree with the specific total you have listed for the National Cancer Institute, but again, I want to repeat I do agree with the general thrust of what you appear to be trying to do in terms of making priority decisions.

NIH POSITIONS

There is one area where I don't feel we are doing enough for cancer or the other Institutes, and that is the area of positions. NCI has had a budget increase of $500 million, over 300 percent in 5 years. Yet their staff has increased by only about one-third.

Dr. COOPER. I would say so.

Mr. OBEY. Isn't the implied result that you are putting a greater burden on good research scientists to be contract administrators to some degree?

Dr. COOPER. No, sir, the Director of the Cancer Institute has repeatedly appealed for additional positions, and again the decisions on these are made on a priority selection basis, with the following caveats of operational reality, if I can say it that way. One is that the Cancer program does have prime contractors which you do not see in our personnel numbers. They have some management capability that——

Mr. OBEY. I am not just talking about Cancer here, I am talking about all of the others.

Dr. COOPER. I think the overall problem is a different problem than the one in Cancer. Cancer has received some modest increase in positions. They have also had some techniques available for supervision and accountability in personnel use that others have not utilized, because of either their authorizations or size of their program. Finally, although we use, from time to time, rules of thumb about how many people for how many dollars, this is not a linear relationship.

In accordance with the President's wish, we have restrained our personnel allocation. All of the Institutes, and Dr. Fredrickson himself, have made appeals repeatedly for additional positions in these programs. But I have also the same case in five other agencies for which I have to make priority choices. The total number of slots available range around 47,000 positions. We have a certain amount of those that are in the direct service categories, such as in the Indian Health Service. Then, again, I am faced with a priority decision situation when we have new programs to implement, which we never had before on a regular basis until the last few years along with the new programs, we have increasing service commitments, and also increasing research commitments in virtually all of the agencies.

GOVERNMENT VERSUS PRIVATE RESEARCH

Mr. OBEY. What I am trying to get at, Doctor, is it seems to me occasionally, if not often, research could just as easily and cheaply be done by Government scientists as being conducted for profit by private industry. There have been certain cases brought to my attention where some of the research done on the outside has been so shoddy that some of it has had to be redone in-house afterward. I see Dr. Finklea sitting back here, and I know he knows a couple of occasions to which I am referring. I just wonder whether the situation really isn't the same at NCI.

Dr. COOPER. Well, I am aware of some of the circumstances that you have referred to, where studies that have been contracted for by Federal programs, and done by private industry, have been unsatisfactory, and have been useless or even fraudulent. I am not aware of any in this category under the National Cancer Institute program.

There have been other agencies under my jurisdiction that have questioned the adequacy of contracts in certain areas or, indeed, have questioned their own laboratory programs. But in this case I cannot say, Mr. Obey, that I know of any particular contracts. If you have some information on that I will be glad to look into it.

I don't know of any specific ones in cancer.

STAFFING AT THE NATIONAL CENTER FOR HEALTH STATISTICS

Mr. OBEY. All right. Let me switch to a different subject. Correct me if I am wrong. My understanding is that the National Center for Health Statistics has had some problem in catching up on their compilation of health data because of a shortage of positions, and that as a result they have quoted only half of the health data from 1972.

Dr. COOPER. I am not aware of that. I have been aware that for the past 5 years they were running way behind. A commitment was made a few years ago to improve both the management and support of the Center. The report that I have is that progress is being made on making the statistics more current, and maintaining quality has been a successful activity. Perhaps Dr. Endicott could comment on it.

Dr. ENDICOTT. We have had a chronic problem in providing current data on health statistics, going back many years. In part this can be attributed to shortages, in the staff, but I think to a much greater extent it is attributable to previous failure to adopt promptly modern technology, so as to speed up the process. Let me give you an example. For many years vital statistics, such as births and deaths were submitted as photocopies of initial service, often in the doctor's handwriting, which is not always too legible.

The task of converting this kind of data is time-consuming and is a very labor intensive activity.

Mr. OBEY. I understand that. My question simply relates to the 1972 problem. Is my information wrong?

Dr. COOPER. I don't know, Mr. Obey. I will look into that and check that for you. I have not been aware of this.

STAFFING AT NIH

Mr. OBEY. Well, it is my understanding that because of the 1972 problem you have a problem with the cancer map program, for instance, that is for the first time giving us overall information in exactly what is happening with cancer in each county across the country. Because of a position shortage at NCHS only half the '72 labor data was tabulated and that makes the data unusable for many epidemiological purposes including the cancer map program. Everything we know about cancer in 1972 has to be thrown out. It is my further understanding that the addition of 15 to 17 positions at NCHS could take care of this problem, and I wonder whether we are not being penny wise and pound foolish in this instance.

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Also in this same regard you have NIEHS? You request an $8.3 million increase this year; right?

Dr. COOPER. Total for the National Institute of Environmental Health Sciences?

Mr. OBEY. Additional.

Dr. COOPER. The additional, yes.

Mr. OBEY. But, you cut back 33 positions.

Dr. COOPER. Yes, the allocation within the National Institutes of Health was distributed that way.

Mr. OBEY. Why? Does that mean that we are going to have to have more of private industry developing tests on chemicals which they manufacture rather than having the Government do it itself?

Dr. COOPER. No, I hope it does not mean that we do not fulfill our responsibilities in maintaining the need to have Federal leadership in developing what is a Federal responsibility.

Mr. OBEY. Well, how are they going to develop these tests? When I was down there I took a look at the program and it is pretty impressive especially the new short-term bio-assay testing techniques programs being developed. It would seem to me that it would have a potential for saving an awful lot of money, not just to people with medical problems, but also the industry itself. I don't see under those circumstances why you would cut back 33 positions.

Dr. COOPER. Well, let me say, not to pass the buck, I have allocated the positions to NIH. NIH allocated them to the different Institutes. If any of these allocations that are called to our attention are resulting in impediments of a serious nature, I am sure that the Director of NIH would reconsider the allocation within his total position allowance, as I would within mine, and come back to the committee with a request for reallocating within our ceiling.

Perhaps Dr. Fredrickson would comment on that decision.

Dr. FREDRICKSON. Mr. Obey, I would be very pleased to be able to submit that information for the record. I would like to be certain that this is correct that we are recorded as reducing positions there by 33.

FEDERAL EMPLOYMENT

Mr. MILLER. Mr. Obey, just one general word. Both the Congress and executive branch are trying to cut back on Federal employment and if Federal employment goes up, the Congress gets just as upset as the executive branch, so we say don't cut back on good things like research or Public Health Service Hospitals, cut back on bad things, like overhead. We really feel we tried to give our employment distribution that priority. For example, I don't think Dr. Cooper's own immediate office has gotten a new position for years now. They are clobbered every year, so you are trying to reach mutually exclusive objectives. You cannot cut back on overall Federal employment and at the same time increase all of these program staffs.

Mr. OBEY. You know, I give that same speech to my mayors who come to me in April and say damn it, you have to give us $6 million for this or that and in October they say, Obey, you are a crazy idiot, you are spending the country into brankruptcy. But I see a serious problem here getting more attention all of the time, not just in the media, but people back home. People are getting concerned with the

whole question of what chemicals do to us, and I don't see how you can justify that. I understand the restraints that you are operating under, but maybe those restraints ought to be looked at in this regard.

Let me switch to just about three more questions.

Dr. COOPER. Well, we will review that, Mr. Obey.

Mr. OBEY. OK.

[The information follows:]

While there is a difference of 33 positions for the National Institute of Environmental Health Sciences between those authorized for fiscal year 1976 (271), and those requested for fiscal year 1977 (238), this difference is a result of the recent Labor-HEW Appropriations Act for 1976. The President's budget for 1976 and the request for fiscal year 1977, regarding this Institute's positions were the same (238), until the Labor-HEW 1976 appropriation conference table was released. The fiscal year 1976 positions were then increased to reflect this change.

ENVIRONMENTAL PROGRAMS

Dr. COOPER. We do give the environmental program high priority in our forward plan, and we will look at the allocation and discuss that with the Director.

Mr. OBEY. I see Dr. Finklea in the back, and let me ask you about something I raised yesterday. Would you give me a status report on the interim facilities at NIOSH?

Dr. COOPER. I think Dr. Finklea could do it directly and authoritatively and I wouldn't have to turn to him and say is that right? Dr. Finklea?

Dr. FINKLEA. Yes, sir.

Mr. OBEY. Could you tell me, for instance, is there adequate space available for the program approved by Congress last year for NIOSH—the increase in positions, et cetera? And could you tell me what space was available to you before and what space is available to you now, after the recent relocation?

Dr. FINKLEA. Yes, I can, Congressman Obey. We will also give you a written summary of that for the record, if you would like. Basically, we are in the middle of moving into interim facilities in Cincinnati which are safer and more adequate. I think these facilities would have been adequate for the program as was budgeted by the administration. With the passage of the current budget we will be negotiating with the General Services Administration and with the Environmental Protection Agency that is colocated with us to assure that we can obtain the additional space that may be needed in that area.

We do not have that space at this time.

NIOSH CINCINNATI FACILITY

Mr. OBEY. So you need more space.

Dr. FINKLEA. We do have some residual problems since the program was expanded by the Congress in fiscal year 1976, that is correct.

Mr. OBEY. Well, if you would expand on that for the record I would appreciate it.

Dr. COOPER. We have a summary for you, sir.

Mr. OBEY. All right. Good.

[The information follows:]

NIOSH SPACE SUMMARY

In November 1975 the Institute developed its interim facility needs which indicated that approximately 170,000 square feet of laboratory and office space was necessary to house the approximately 523 people which were anticipated in Cincinnati as a result of the pending appropriation. Since that time the budget authority for the positions has been received; however, we have not been able to acquire the full 170,000 square feet for interim facilities. As a result of negotiations with Environmental Protection Agency (EPA), it has been necessary to assign approximately 30,000 square feet of space in the two facilities back to EPA and an additional 3,500 square feet continues to be occupied by the Food and Drug Administration (FDA). As a result, NIOSH has available at the present time only 131,000 square feet. This is only 10,000 square feet more than was available prior to the initiation of the move; however, one great advantage will be the consolidation from four locations into two locations, a much more manageable situation.

Mr. OBEY. Will there be any major renovation required?

Dr. FINKLEA. Yes, sir, in one of the lease facilities we will require some renovation. I think that will be within the renovation improvement funds that are available within the Department, though, sir. We do not anticipate reprograming action for that.

Mr. OBEY. What kind of dollars are you talking about?

Dr. FINKLEA. The best estimate we have, sir, was about $1.2 million. It's my understanding that this would be in the lease cost arrangement for interim facilities. The Department working together with the other Federal agencies has come out with an arrangement that would be most efficient.

OCCUPATIONAL SAFETY AND HEALTH PROFESSIONALS RECRUITMENT

Mr. OBEY. Let me ask this, and I don't mean to be irritating about it. I would like you to explain to me frankly what problems you are having in recruiting occupational safety and health professionals.

Dr. FINKLEA. I think first of all the pool of professionals from which we can recruit is quite small. Very frankly it has not been growing with the national demands in this area. I think the second problem we have had, and we have discussed this before with this committee, has been that we were recruiting in our major research area into an inadequate facility which made it very difficult to get people from this very shallow pool to come in to work with the Institute. I think we have made progress in this area, principally due to the very devoted efforts of people from the center for disease control who have been helping us with the accelerated recruiting program.

The Institute is up to its authorized ceiling but this is before the apportionment based on the increased 1976 budget becomes available. We have found that it is difficult to get key professionals in this area to locate in the Cincinnati metropolitan area. However, we found that when these people do relocate they subsequently do seem to like the area very much.

I think this experience parallels that of major industries in the area, so, we have had a combination of a facility problem there, plus a shallow pool to recruit from, plus some people not understanding the community as well as they do after they have lived there a while.

Mr. OBEY. What I would take from that statement is that while you might personally be satisfied with Cincinnati, and that you feel that a number of people now located there might be, but that there has been at least a portion of your recruiting problem which may have been related to the fact that you are located in an area like Cincinnati.

Dr. FINKLEA. Well, I think geographic location did give us at least part of this difficulty, that is correct. I might say, when I came to work for the Institute, I was quite willing to live in Cincinnati myself and would be glad to do so at the preesnt time. I have found it a delightful community.

Mr. OBEY. Well, thank you.

Dr. FINKLEA. I might also say I have lived in a number of different communities and I have found all of them delightful.

### TRAINING GRANT TERMINATION

Mr. OBEY. Doctor, your budget submission would terminate training grants, wouldn't it? If the training grant program is continued, wouldn't you have a more adequate pool of professionals from which to recruit? Dr. Finklea indicated there is a recruitment pool problem.

Dr. COOPER. The budget, as we would implement it, would eliminate the training program support from the Federal Government.

It would not necessarily result in the fact that nobody would be trained in this area. The total training effort is not supported entirely by Federal funds, so that we would not expect that there would be elimination of the whole training pool.

On the other hand, it would be true that undoubtedly it would be reduced by this, and we do need to have training in the area in general from which to derive the pool.

Mr. OBEY. Well, let me ask both you and Dr. Finklea this question: If your manpower pool is so shallow, would not that shortage effectively block the implementation of the Occupational Safety and Health Act?

Dr. COOPER. I think the absence of people of the right kind always impedes the rate at which we can implement an act. I would say just parenthetically here that when we get the final recommendations of the study that was asked for by the Congress from the National Academy of Sciences on manpower needs, and on total needs, I am sure the administration would be quite willing to relook at their recommendations toward training.

### MATERNAL AND CHILD HEALTH POSITIONS

Mr. FLOOD. Mr. Roybal.

Mr. ROYBAL. Dr. Cooper, just one question. Have you yet filled the 58 maternal and child health positions as the Congress directed some 2 years ago? And also indicate how many of those are assigned full-time to maternal and child health responsibilities.

Dr. COOPER. With the exception of the normal turnover of 3 to 5 percent over each year the 58 positions have indeed been filled. I would point out, however, that the Bureau of Community Health Services, where the maternal and child health programs are organizationally located, is functionally oriented and structured. Within the context of such a structure positions are not assigned by program but rather by type of activity or function of the organizational unit. The application of total positions available for all Bureau of Community Health Services activities including MCH, is viewed in terms of how many man-days and man-years of effort are needed to effectively carry out

the programs. When considered in this light, it can safely be stated that the maternal and child health activities are being adequately provided for. From a purely technical point of view and as part of the accounting procedures in place in the Bureau, individual staff members are identifiable against MCH positions but they carry added responsibilities for all BCHS programs. Likewise, other staff members identified against other programs share in carrying out MCH activities.

Mr. FLOOD. Mr. Shriver.

CANCER RESEARCH

Mr. SHRIVER. Dr. Cooper, how much would it take to fund your cancer research program in 1977 at the same level Congress appropriated for 1976?

Dr. COOPER. In 1977, it would take $852 million to maintain the cancer research program at the same level as the 1976 appropriation.

FUNDS NEEDED TO MAINTAIN 1976 LEVEL IN 1977

Mr. SHRIVER. Dr. Cooper, what funds would it require just to keep all the Institutes 1977 efforts at the same level at 1976?

Dr. COOPER. I will supply that for the record.

[The information follows:]

*1977 Funds Required to Maintain 1976 Level*

| | *Thousands* |
|---|---|
| Cancer | $852,000 |
| Heart | 438,166 |
| Dental | 56,027 |
| Arthritis | 196,514 |
| Neurology | 148,460 |
| Allergy | 135,615 |
| General medical sciences | 224,624 |
| Child health | 140,209 |
| Aging | 26,220 |
| Eye | 58,380 |
| Environmental health sciences | 47,104 |
| Research Resources | 137,399 |
| Fogarty International Center | 7,852 |
| Office of the Director | 16,234 |
| National Library of Medicine | 35,234 |
| Total biomedical research | 2,520,038 |

[1] The amounts shown above are those required to fund the same number of competing grants as in 1976 and to provide for all continuation costs.
[2] No increase over the 1977 President's budget is required.

NOTE.—Excludes buildings and facilities.

CINCINNATI LOCATION

Mr. SHRIVER. Has the final decision been made to leave the NIOSH in Cincinnati, Ohio? Since most of the people are already there, that would seem to be logical.

Dr. COOPER. Yes; in December 1975 the Department, as requested by Congress, submitted a report to the Committee on Appropriations, U.S. House of Representatives on the location and housing of research activities of the National Institute for Occupational Safety and Health. The decision of the site selection committee was that this activity would remain in Cincinnati.

MEDICALLY UNDERSERVED AREAS

Mr. SHRIVER. We have been talking about medically underserved areas for some time, and your statement indicates new emphasis on meeting this need. I'm not sure we are all talking about the same need. There are rural areas in my State of Kansas which have difficulties recruiting medical personnel and obtaining and maintaining adequate facilities. I am sure this is the case in most congressional districts. Yet there has been little if any activity by the Federal Government in helping meet the needs of these communities—lots of talk, but not much in the way of results. I wonder if you would comment on this and tell us your official definition of a medically underserved area. I hope we're not just talking about one region of the country, because there is a genuine need all over.

Dr. COOPER. I believe we are talking about the same thing because our official definition is based on the legislation. Under section 329 of the PHS Act, the Secretary is charged to designate areas with "critical health manpower shortages" for the assignment of National Health Service Corps personnel. The criteria used to identify critical health manpower shortage areas are physician or dentist to population ratio, the physician ratio is 1 to 4,000 and the dentist ratio is 1 to 5,000.

Currently there are 1,400 areas designated as critical health manpower shortage areas around the country. Of these, about 550 have been approved as eligible for National Health Service Corps assistance. The Corps will be staffing 340 of these sites and about 852,000 people will be served by the end of fiscal 1976.

As defined in Public Law 94–63, medically underserved population is the population of an urban or rural area designated by the Secretary of HEW as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Criteria used to define these areas are: physician to population ratio, infant mortality, proportion of low income in population and proportion of elderly in population.

There are currently 1,400 counties including 1,516 minor civil divisions and census county divisions and 5,228 census tracts designated as medically underserved areas having a shortage of personal health services. An estimated 49,720,000 people reside in these areas of which 1,872,000 are being served by 234 Community Health Centers located in 41 States also District of Columbia, Puerto Rico and Virgin Islands.

With respect to health problems in rural areas, we have been undertaking a Rural Health Initiative which addresses obstacles encountered in serving various population groups, such as migrant and seasonal farmworkers, and in serving medically underserved areas and those with critical health manpower shortages. During the last fiscal year 47 projects were initiated under this effort in 26 States and Puerto Rico. In 1976, if the full appropriation level becomes available for expenditure, we expect to support a total of 77 Rural Health Initiative projects.

Mr. SHRIVER. Would you explain the administration's consolidation plan for health programs in respect to the community mental health centers programs? I don't understand how you can fold this into a block grant program and still meet the intent of Congress when we extended this program last year? What happens to existing centers?

Dr. COOPER. Mr. Shriver, the proposed block grant would not require the States to follow the detailed legislation enacted by the Congress. The States would have flexibility to set up the type of mental health program best suited to their needs, although at least 5 percent of the block grant funding would have to be spent on community and environmental health activities, including community based mental health services. We would hope and expect that, because of the success of the current program, the States would continue it in a way very similar to the current form.

Existing grants would be guaranteed at least 80 percent of their fiscal year 1976 grant level in the first year, 50 percent in the second year, and 25 percent in the third year.

I also understand that the President's proposal will guarantee that no State will receive in fiscal year 1977 and subsequent years any less funding than it received in fiscal year 1976 for the programs being consolidated.

In fact, the block grant could be a source of a level of permanent Federal funding for Community Mental Health Centers; whereas the existing CMHC staffing or operating grant program is limited to 8 years of Federal support. Of course, as I indicated, the priority given to any individual program would be determined by the States.

Mr. CONTE. Doctor, as a health professional, do you feel this budget is adequate and in line with the priorities of this country?

Dr. COOPER. Considering the current economic situation, I feel that this represents a reasonable budget under the circumstances. The total health budget for 1977, including medicare and medicaid, is $33.6 billion. This compares to a health budget of $30.4 billion in 1976, $17.2 billion in 1972, just 5 years ago, and a budget of only $6.8 billion in 1967. You can see from this tremendous growth in Federal resources for health that health is indeed a high priority. The HEW budget accounts for 35 percent of all Federal outlays whereas 10 years ago it represented less than 23 percent of the total. The increases in the Federal budget for health represent a substantial part of that overall percentage increase. I conclude from this that health has been placed rather high on the overall list of Federal priorities, and I believe that our 1977 budget is adequate to address the health care problems for which we are seeking solutions.

### MANPOWER SUPPLY AND DISTRIBUTION

Mr. CONTE. What steps have been taken to implement your suggestions of last year to improve the maldistribution and specialization problems which seem to be getting worse?

Dr. COOPER. We have proposed legislation to the Congress in the form of the Health Professions Education Amendments of 1975: H.R. 11119 and S. 2748. Several programs in the bill are directed toward alleviating problems of specialty and maldistribution of health professionals. For example, it includes a program of National Priority Incentive Awards and Capitation. Under this program the schools of medicine, osteopathy, and dentistry would agree to set aside a percentage of their first year places to applicants who agree to apply for a scholarship under the Health Service Scholarship program. The Health Service Scholarship program combines several other scholarship programs into one. This program requires the participants to

serve in health manpower shortage areas for each year of scholarship support, not less than 2 nor more than 4 years. The family medicine program will give special consideration to specialty and maldistribution problems. The subject includes $39 million for this program, an increase of $24 million compared to funds available in 1976. We are requesting $18 million for primary care residency training in fiscal year 1977. No funds are specifically available for this purpose in fiscal year 1976. Also the Area Health Education Centers program will be broadened to promote community-based training of health professions and programs to upgrade skills of health professionals in the community.

Mr. CONTE. I have quite a bit of mail concerning capitation grants. It seems that this will especially put the crunch on middle class families who would not otherwise qualify and we both know how out of sight these tuitions are getting. How do you justify phaseout of these grants for veterinary, optometry and podiatry schools?

Dr. COOPER. One of the major problems in providing adequate and efficient health care to the nation is the problem of specialty and maldistribution of health personnel. One of the ways we are addressing this problem in the proposed legislation and in this budget request is through capitation incentives. Within available fiscal resources, we propose the phaseout support to optometry, podiatry, and veterinary medicine schools because there are very few specialty and geographic distribution problems for these professions.

Mr. CONTE. What will be the funding for the National Health Services Scholarships in 1977 as compared to 1976? How many students are involved?

Dr. COOPER. The 1977 request of $35 million is an increase of $12.5 million over the 1976 funding of $22.5 million for the National Health Services Scholarships program. In 1977 approximately 4,650 recipients will receive support as compared to 2,741 recipients in 1976.

Mr. CONTE. In 1976 emphasis as placed on improving the regional health administrations work programs efficiency. What is the outcome of the analysis of the flow of management information to the regional offices and what kind of recommendations were made?

Dr. COOPER. Recognizing that the work program as entering the third year of a 5-year implementation plan during fiscal year 1977, my office undertook a detailed analysis of the RHA work program this last year. This analysis resulted in major changes in the process, which should allow a clearer identification and agreement on program outputs expected on the PHS regional offices by central office agencies. The process will also be streamlined by minimizing the paperwork and making the resource guidance from central office agencies more realistic for operational planning at regional office level. In addition, we are initiating a quarterly priority output reporting system from regional offices to central office agencies. These changes will also improve the information flow between central and regional offices and the utility of the work program. These changes will enable the regional health administrators to more effectively carry out their responsibilities and accountability for the operational components of the PHS.

Mr. CONTE. What will be the relative positions of State, local and private institutions, in terms of their share of health care delivery pro-

grams. Will they have to contribute a larger percentage this year and in succeeding years?

Dr. COOPER. As you are aware, we are proposing to transfer funding and responsibility for the administration of a number of health care delivery programs to the States in 1977. The 1977 budget is really a stand-still budget pending congressional approval of this block grant proposal. Under the legislation that is being drafted, the total Federal funding for the support of these programs would increase by $0.5 billion each year. The question of whether or not the States would have to contribute a larger percentage of funds in future years is tied to the ability of the States to control medicaid costs. If medicaid is brought under reasonable control, the States would have greater flexibility to make their own decisions regarding health priorities. If medicaid costs continue to escalate, in order to maintain health programs at their current levels, the States would have to contribute a greater share.

Mr. CONTE. Last year HEW published its own reports on the deficiencies of nursing homes and their care. HEW then came up with "Long Term Care Facility Improvement Campaign Analysis." What is the result of these studies and when can we expect actual implementation of these findings?

Dr. COOPER. In January, 1974, the Department issued a report entitled, Enforcement of Life Safety Code Requirements in Skilled Nursing Facilities. In response to the recommendations contained in this report, the Department has taken the following action:

1. The number of Federal staff dealing with life safety code enforcement has been increased;

2. Administrative controls to insure appropriate and timely certifications and terminations of LTC policies have been improved through the issuance of operating and policy manuals for the regional enforcement offices. In addition, enforcement bulletins have and are being issued concerning technical guidance on interpretation and enforcement of the life safety code; and

3. A management information system has been implemented which includes centralized data for monitoring life safety code compliance.

On June 21, 1974, the Department of Health, Education, and Welfare announced a campaign to improve long-term care in nursing homes. One of the projects in phase I of this campaign was a fact-finding survey of skilled nursing facilities. The survey asked three basic questions: Who are the patients? How are nursing homes managed? How good is patient care? Designed cooperatively by several Government organizations and consultants from leading universities the survey was conducted by teams of professionally trained experts. A complete report of the survey findings was published by the Department, July 1975; Long-Term Care Facility Improvement Study: Introductory Report and contains specific findings about patient characteristics, facility management and patient care. One specific finding, namely that the survey certification process focuses on the institutional framework within which care is provided rather than on the patient resulted in the announcement on February 12, 1976, of phase II of the Long Term Care Improvement Campaign.

PHASE II

One direct way of improving patient care is to obtain and refine a mechanism by which an individual patient's outcomes can be measured systematically at regularly scheduled intervals. This would provide a method for determining the allocation of resources in a facility including manpower. Thus, services provided would be those actually needed and delivered to patients. This process is called a Patient Assessment Survey.

STEPS TO BE TAKEN IN PHASE II

1. Introduce on a demonstration basis a consolidated patient assessment survey based on outcome measures obtained through a pilot study of long-term care facilities participating in Federal programs.
2. Obtain and refine a process by which an individual patient's outcomes can be measured systematically at scheduled intervals and provide a method for determining how resources should be allocated in the facility.
3. Apply the patient assessment system in operational settings in four to six States involving several HEW regions to develop a uniform patient assessment system.
4. Evaluate results of efforts of the pilot study conducted in the four to six States and make the necessary modifications in the patient assessment process.
5. Assess all standards in the present medicare (title XVIII) and medicaid (title XIX) to identify those standards that relate to facility improvement and those which are essential to provide an evaluaton of patient care.
6. Subsequently introduce consolidated survey/certification procedures into all 10 HEW regions.
7. Assess reimbursement mechanism (medicare-medicaid) with a view toward developing reimbursement procedures with incentives linked to performance (i.e., based on actual services provided).

It is anticipated that phase II will require 3 to 4 years for full implementation.

Mr. CONTE. Last year you stated you were estimating the cost of the aquisition and organization of information concerning medical malpractice insurance, have you now any recommendation in this area?

Dr. COOPER. Thus far this fiscal year $238,040 plus the salaries to support 6.21 professional man years have been expended on the Department's efforts in malpractice.We plan that during the remainder of this fiscal year an additional $250,000 will be spent, for a total of $488,040. Of this amount, $478,035 and about 54 percent of the professional staff time has come from the Public Health Service. We anticipate that expenditures and staff time for next fiscal year will be similar.

Mr. FLOOD. Thank you very much.

Dr. COOPER. Thank you, Mr. Chairman.

MONDAY, FEBRUARY 23, 1976.

# HEALTH SERVICES ADMINISTRATION

## WITNESSES

**DR. ROBERT VAN HOEK, ACTING ADMINISTRATOR**
**DR. EDWARD D. MARTIN, DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES**
**DR. MICHAEL H. GORAN, DIRECTOR, BUREAU OF QUALITY ASSURANCE**
**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. The committee will come to order.

The Health Services Administration is here today and the presentation will be made by Dr. Robert van Hoek, the Acting Administrator.

We have a biographical sketch of you, Doctor, which will be placed in the record at this point.

[The sketch follows:]

BIOGRAPHICAL SKETCH

Name: Robert van Hoek, M.D.

Position: Assistant Surgeon General (08), U.S. Public Health Services, 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 to present, Acting Administrator, Health Services Administration.

July 1974 to present, Deputy Administrator, HSA.

January 1974 to 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, Acting 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).

1963–64, Trainee in Administration of USPHS Extramural Programs, Grants Associates Program, NIH.

1961–63, Head, Metabolism Branch of Radiation, Physiology Division, Armed Forces Radiobiology 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, Dayton, Ohio.

1954–57, Resident, Internal Medicine, Bronx Veterans' Administration Hospital, Bronx, N.Y.

1953–54, Intern, Medicine, St. Luke's Hospital (New York).

Memberships: 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, 1972; PHS Meritorious Service Medal, 1970; Alpha Omega Alpha Honor Medical Society, 1952.

Mr. FLOOD. I see you have some people with you.

Dr. VAN HOEK. Yes, Mr. Chairman, may I introduce the witnesses who are accompanying me today. On my far left is Dr. Michael H. Goran, Director of the Bureau of Quality Assurance. Next to him is Dr. Edward Martin, Director of the Bureau of Community Health Services. On my immediate left Mr. Harell Little, Director of the Office of Financial Management, HSA, and on my far right is Mr. Charles Miller, from the Office of the Secretary, and Dr. Robert Streicher, who is the Director of the Bureau of Medical Services.

PREPARED STATEMENT

Mr. FLOOD. I see you have a prepared statement, Doctor. How do you want to handle it?

Dr. VAN HOEK. With your permission, Mr. Chairman, I would like to read the opening statement. It is relatively brief.

Mr. FLOOD. All right.

Dr. VAN HOEK. Mr. Chairman and members of the committee, I appreciate this opportunity to discuss with you the programs of the Health Services Administration and the budget request for fiscal year 1977. 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 only the programs of the first three Bureaus.

The programs of the Health Services Administration promote the accessibility, efficiency, and quality of health care services delivered to broad segments of the population of the United States. These goals are achieved first by providing leadership in innovative health service delivery programs operated directly by the Health Services Administration or funded through formula or project grant mechanisms and, second, by administering programs designed to improve the organization, effectiveness, and quality of care of health services delivery. In pursuit of these goals, the Health Services Administration has organized its program efforts around four strategic roles. These are (1) to place appropriate health personnel in underserved areas, that is, to build primary health care capacity; (2) to maintain such capacity, especially in circumstances where it cannot become self-sustaining; (3) to improve the organization and efficiency of health care delivery; and (4) to assure the quality of federally financed health services.

The National Health Service Corps represents the Department's major focus of effort for the building of health services capacity in areas having critical shortages of the manpower required to deliver health care. During the early years of the National Health Service

Corps program, major efforts were required to build up a manpower resource capacity to provide staff for communities with critical health manpower shortages. Having established a relatively stable and effective recruitment system, we are now better able to redirect more effort and resources to the more fundamental goals of assisting communities in developing the capacity to independently maintain viable health practices, and developing policies that will encourage health professionals, once placed, to remain on a non-Federal basis. In 1977, we project 150 sites will have become independent, serving approximately 450,000 people, which is in addition to 820,500 people served by NHSC assignees. In 1977, the retention rate is expected to increase to 40 percent, which will mean that of the assignees completing their 2 year contract period, about 100 will be either extending for a third year or will be staying in the communities as private citizens. The budget request for this program includes $24,529,000 and 676 positions, an increase of $7 million and 125 positions over the 1976 level.

The programs with the principal mission of maintaining health service delivery capacity in health scarcity areas include the Community Health Centers, Maternal and Child Health, Family Planning and Migrant Health projects. These programs will provide services to approximately 13 million people in 1976. Program management improvements have increased the number of people served and the quality of service provided by these programs. For example, during 1976 the Community Health Center reimbursement level will increase from 20 percent to 22 percent and the primary physician encounter rate will increase from 2.5 to 2.7 encounters per hour. During 1976, the application of health care standards for all of these programs will be implemented. Special attention, consistent with the new Health Services legislation, will be initiated. For example, dollars will be targeted to high impact migrant areas and to programs addressed to problems of teenage pregnancy.

The 1977 budget for these programs requests the same dollar level as in the President's original 1976 budget. This estimate will assure program continuity while action is being taken on the proposed legislation for a health block grant.

In addition to these grant programs, the Health Services Administration has maintained services capacity through the direct provision of health care to certain statutory beneficiaries. The 1977 budget proposes to revise the principal method of providing inpatient care to these Public Health Service general hospitals by transferring to community use or closing the eight Public Health Service hospitals. Primary beneficiaries would instead receive inpatient care in community facilities on a contractual basis with the Public Health Service. Outpatient care will continue to be provided through Public Health Service clinics.

The Health Services Administration will continue efforts to improve the organization and efficiency of health care delivery by fostering the establishment and growth of Health Maintenance Organizations as an alternative to existing health care delivery mechanisms. During fiscal year 1977, we expect to fund 24 planning and 15 development grants. These grants, in addition to projects previously funded, plus the 14 loans for initial operations, will eventually generate 50 HMO's which, at maturity, will have a potential of

serving 1,500,000 enrolees. Program emphasis will be placed upon technical assistance to potential health maintenance organizations and guidance in the implementation of the HMO Act.

A second important effort to improve the organization of health care delivery is the Emergency Medical Services program. This program provides assistance in establishing systems for the delivery of emergency medical services that enhance patient survival and care from an initial incident on through definitive care. Such systems involve 15 well-defined components integrated to maximize the utilization of all care resources within a specified geographical area. Although the program is too new to have accumulated data to show its effects on a nationwide basis, data are available from several communities showing the saving of lives.

Each State and territory has now established an organization to be responsible for emergency medical services activities. It is anticipated that, on a cumulative basis, funding will have been provided to support 120 emergency medical services systems in some form of operation with a potential impact on 60 million persons.

The PSRO program is one of the most significant quality assurance activities now being implemented throughout the country. It represents a unique opportunity to improve the quality and utilization of medical care services and should result in effective controls on health expenditures.

PSRO's are organizations of physicians who apply systematic peer review methods to determine the necessity, appropriateness and quality of medical care financed by the medicare, medicaid and maternal and child health programs. Prior to the enactment of the PSRO statute in 1972, this authority rested with the medicare intermediaries and the medicaid state agencies rather than with physician organizations. There are now 106,000 physicians who are members of the existing 120 PSROs. This represents about one-half of the physicians in these areas. Early impact data from those PSROs, which have been performing review for an extended period of time, indicates that PSRO hospital review consistently results in reduction in lengths of stay and some reductions in hospital admissions and services. We have available, and will provide, additional information on the impact of PSRO review.

There are now 65 conditional PSROs which will review approximately 1,900,000 medicare and medicaid admissions in over 1,700 hospitals during fiscal year 1976. About 80 percent of these conditional PSROs have begun review since last July when they were designated as conditional PSROs. There are 55 planning PSROs. Many of these planning PSROs are already qualified for conditional designation, and we expect that all of these will be qualified for conditional designation within the next 6 months.

The budget request of $62 million includes a $14,418,000 increase over the 1976 level. This increase will allow the PSRO program to cover all 203 PSRO areas throughout the country. Eventually this will permit full replacement of the duplicate, federally-required hospital utilization review system now in existence in about all of the Nation's 7,000 hospitals. This request will permit the continuation of 65 conditional PSRO's, the conversion of 55 PSRO's from planning to conditional status and the funding of 83 new PSRO's.

In summary, Mr. Chairman, the Health Services Administration will continue its efforts to improve the distribution of health resources, to monitor the quality of health care delivery, and to reduce the rise in health care costs.

My colleagues and I will be pleased to answer any questions.

EVIDENCE OF STATE SUPPORT

Mr. FLOOD. Well now, Doctor, the budget before us looks very much like the 1976 budget. You are again assuming greater support from the States and the local governments. Has anything developed over the weekend, in the last few days, to give any credence to this assumption?

Dr. VAN HOEK. Mr. Chairman, the budget that we are considering today has two facets to it.

One is that we have submitted a budget along the usual program lines; the budget levels are the same as those proposed, with some exceptions, in the 1976 original President's budget on the assumption that we would obtain greater cost sharing from State and local resources.

Mr. FLOOD. That 's the question.

Dr. VAN HOEK. In addition to that, the current budget proposal is based on the assumption that the Congress will favorably consider the block grant proposal, which for a total of 16 programs, including the ones in our account, would have a total of $1 billion more in fiscal 1977 than they did in fiscal 1976.

Mr. FLOOD. Where is the credence to the assumption you are going to get more from the State and local people? Have you got a crystal ball, or what?

Dr. VAN HOEK. We have in the situation of the comprehensive health centers achieved some increase in third party reimbursement from 20 percent to 22 percent; aside from that, we have not had increased cost sharing as we had anticipated when we discussed the 1976 budget.

Mr. FLOOD. Well, an awful lot of this budget is based upon the assumption you will. An awful lot.

Dr. VAN HOEK. I think it's based more on the assumption that the Congress will favorably act on the bloc grant proposal and less on cost-sharing.

Mr. FLOOD. Take a look at page 23 of your justification. Now, Doctor, under this budget you are going to support 97 new community health center projects. Now what will happen to these centers you are talking about? Will they be able to support themselves or do they just shut their doors? You close these down and you are going to have about 500,000 people that are not going to receive any medical care.

BLOCK GRANT PROPOSAL

Dr. VAN HOEK. If the results of the current budget and legislative discussions result in no block grant, no block grant authority with the increased funds, and we are unable to achieve greater cost-sharing at the State and local level, then those are our estimates of the reduction in services that will occur.

As Dr. Cooper said on Friday, these are linear projections based on dollars versus people being served. We know this problem will not result in a straight line reduction. These are our best estimates at the

present time, but there are projects that can achieve and maintain services and perhaps even increase their productivity to some extent, so this is an outside estimate of what the reduction would be.

RURAL HEALTH INITIATIVE

Mr. FLOOD. Fine. In this budget you are talking about now, you are proposing to terminate the rural health initiative activity. Suppose you tell us what you accomplished to date so far on this activity and what the future opportunities are going to be if this program is implemented?

Dr. VAN HOEK. In fiscal 1975 we began the rural health initiative by using funds that we were able to free up from existing programs. These were programs of comprehensive health centers, the migrant health program, as well as using the National Health Service Corps assignees. We developed a program which resulted in the awarding of 47 grants to communities for the development of a rural health delivery system, and that amounted to approximately $7.2 million.

At the present time, 41 of those sites are operational and delivering services, 6 are still in the developmental stage. When we made those awards in fiscal 1975 it was with the understanding on the part of the communities and the grantees that, with the exception of the National Health Service Corps assigness, additional Federal dollars might not be available in subsequent years, and they would have to count on this being a 1-year developmental grant.

Mr. FLOOD. What opportunities are we going to lose if this is gone?

Dr. VAN HOEK. The plan is that the 150 assignees will continue to provide health care services to those communities.

The impact of the unavailability of funds may be a limitation on providing care to certain population groups such as the migrant population.

THIRD PARTY REIMBURSEMENT RATES

Mr. FLOOD. I haven't heard that term "Pollyanna" in a long time. Remember Pollyanna?

Now, last year you told us these 157 community health centers would collect $62 million from third party reimbursements in 1976. Now, this material we have before us shows the centers will collect $65,428,000 in 1976. That's an increase of 5.5 percent.

Now, if we were to appropriate sufficient funds to keep all of these centers open, in view of that, what level of reimbursements would you expect to collect in fiscal 1977?

Dr. VAN HOEK. I am sorry, Mr. Chairman, I didn't quite follow that.

Mr. FLOOD. Well, you told us that you have 157 centers, that they collected $62 million from the third party reimbursements in 1975. Now, this material you have here indicates the centers will collect $65,428,000 in 1976. I repeat, that's up 5.5 percent. All right, if we can give you sufficient funds to keep all of these centers open, what is the level of reimbursement that you expect to collect in fiscal 1977 in view of that?

Dr. VAN HOEK. Our anticipated third party reimbursement, based on the third party reimbursement estimates that we currently have, roughly 22 percent for comprehensive health centers, is about the maximum that we believe can be achieved.

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Mr. FLOOD. You went up 5.5 percent?

Dr. VAN HOEK. From 1975 to 1976, we went from 20 percent to 22 percent.

Mr. FLOOD. From $62 to $65.4 million. Now, if we give you enough money for all of these centers, well, what will your reimbursements be in 1977?

Dr. VAN HOEK. About the same, $65 million.

Mr. FLOOD. The same?

Dr. VAN HOEK. Are you asking about if you gave us the same dollar level as in the 1976 appropriation or in the 1977 estimate?

Mr. FLOOD. Sufficient funds to keep all of the centers open.

Dr. VAN HOEK. It would be approximately $65 million, 22 percent.

Mr. FLOOD. Well, I tell you what, suppose you amplify that for the record.

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. Recompute those tables in your justifications to reflect continued support for all of the centers.

[The information follows:]

CHC 3D-PARTY REIMBURSEMENT ESTIMATES

[In thousands of dollars]

| | 1975 | 1976 | 1977 |
|---|---|---|---|
| Original estimates | 196,648 | 196,648 | 155,190 |
| 3d party | 62,000 | 65,428 | 54,000 |
| Revised estimates | 196,648 | 196,648 | 196,648 |
| 3d party | 62,000 | 65,428 | 65,428 |

MATERNAL AND CHILD HEALTH AND INFANT MORTALITY

Now, take a look at the material and child programs. You are proposing to cut $110,486,000 from the whole program. Doctor, how do we rank among all of the nations in the world in this matter of infant mortality?

Dr. VAN HOEK. At the present time we rank 15th among all of the countries.

Mr. FLOOD. So we rank 15th. That means we have got a lot of work to do in this area.

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. The answer is yes?

Dr. VAN HOEK. Yes; Mr. Chairman.

Mr. FLOOD. Good. Well, what do you do? Do you have some group standing in the wings off stage left there ready to cover up the reduction in funds and services here, or what?

Dr. VAN HOEK. Mr. Chairman, several points need to be made. One is that the maternal and child health program is not the sole source of funds for delivering health care to mothers and infants. The medicaid program is a major source of financing for individuals of low income. Second, the budget is based on the assumption that we will have new legislation for a block grant program, which contains an increase of $1 billion totally for health services, and 90 percent of the funds allocated to the States are to be devoted to personal health services, with priorities to be defined by the States.

Mr. FLOOD. You certainly have your fingers crossed on the block grants. Right now, however, we stand 15th in the world on this business of infant mortality. Could we improve our standing simply by putting more money into this program or are there other things that have to be done?

Dr. VAN HOEK. Other things have to be done.

DECREASING INFANT MORTALITY RATES

Mr. FLOOD. Well, what has to be done, and who is doing it?

Dr. VAN HOEK. We are addressing this problem with the maternal and child health formula grant, and the family planning programs that we support, through both Title X and Title V. We have to develop better methods of allocating our health care resources to the high risk population groups. The infant mortality statistics on a nationwide basis don't adequately describe the pattern of infant mortality; there are the problems of selected population groups having a much higher infant mortality than the national average.

Mr. FLOOD. Can we improve our standing from 15th by putting more money into this?

Dr. VAN HOEK. Perhaps more money, but I think not just money alone. It requires a targeting of the services and providing access for low income and special target populations to health care, for women of childbearing age and during their period of maternity, and providing adequate care in the immediate post natal period.

Mr. FLOOD. You have had all of this money; why are we 15th? You are telling us nothing new; why are we still 15th. All of this money, all of these dollars. Now you tell me what has to be done.

Dr. VAN HOEK. We have had a set of programs in which the efforts have been targeted to these high risk population groups.

Mr. FLOOD. You sure seem to be off target.

Dr. VAN HOEK. But it's not just a question of health services as an operation unto itself. Health services can contribute significantly, but there are other problems of economic status of the population; we have worked with other agencies both at the Federal, State and local level to develop integrated nutrition programs, to improve the health status of the mothers, both during their pregnancy, as well as for children after delivery. But it is not a simple problem that just money to pay for health services can address.

INFANT MORTALITY RATE OBJECTIVES

Mr. FLOOD. Well, what will all of that do, make us 14½ or what?

Dr. VAN HOEK. Over the long run——

Mr. FLOOD. What will you settle for, 13¾ or what are you shooting at?

Dr. VAN HOEK. I don't have a specific target figure in mind, but the present figures can be improved markedly.

Mr. FLOOD. Where do you get the idea of waiving this block grant thing around as the answer to all of these problems? What has that got to do with this problem? How is the block grant going to get us out of this? You are blocked now.

Dr. VAN HOEK. The block grant is based on the premise that differnt communities, different States have different health problems, and that the nature of the problems can be dealt with more effectively at the local level by the integration of services and the funds that are allocated to the State and community.

The issue of integrating activities such as family planning programs, maternal, and child health programs, programs of other agencies, where there are different legislative requirements, different regulatory requirements, different agencies involved, the whole idea is that the States should have a greater decisionmaking role in setting priorities and targeting the funds and that they can more effectively allocate the resources to the population in need.

DECREASE IN PEOPLE SERVED

Mr. FLOOD. This is the Appropriations Committee and I have a technical question. In fiscal 1976 we added 11 percent to the 1975 level for maternal and child health grants. That's what we did. Now take a look at page 29 of your justifications. Despite all of that you show the services declining. Can you tell us why? How do you add that up? Why?

Dr. VAN HOEK. The reason that the lower estimate of the level of services being delivered is the result of increasing costs for delivering services to crippled children, even though we have had an increase in the dollars available for that program.

Mr. FLOOD. Now, look at the bottom of page 29. Remember I told you to look at page 29, look at the last line there. Decrease in numbers served below the 1975 figure reflects impact of an inflation rate of 7.5 percent." What about that? We gave you 11 percent.

Dr. VAN HOEK. Well, there are two aspects to that. One is that the estimate——

Mr. FLOOD. You fellows better stay away from Bowie or Vegas.

Dr. VAN HOEK. The estimated inflation rate of 7½ percent is part of the problem. The other is that the nature of the conditions being treated through the crippled childrens' program is causing increasing costs, such as patients with hemophilia, cystic fibrosis, and so forth, and it's our understanding that the crippled childrens' enrollment is increasing, particularly because of referrals from the screening programs of the EPSDT, the early period screening diagnosis and treatment program.

IMMUNIZATIONS

Mr. FLOOD. One of the services rendered by the maternal and child health program is the immunization of children. When I look at the budget for the Center of Disease Control, CDC, I see they also have an immunization program. Is this one in the same program and if not, how do they work together?

Dr. VAN HOEK. They are not the same program, but they do work together. CDC provides grants to the States for immunization programs, the States may carry out this immunization program through a number of different service delivery mechanisms and one of those is the maternal and child health clinics, the clinics supported by the maternal and child health program. The maternal and child health program has a major role in actually seeing that children are im-

munized at the community level. Some of the costs of the vaccine used in the projects are paid for through the CDC grants.

Mr. FLOOD. With these two groups working for immunization of children, why do we keep hearing all of the time that the national immunization levels are low? Which of the two groups is dropping the ball, you or CDC?

Dr. VAN HOEK. Neither. The problem with maintaining adequate immunization levels involves several factors. The first is to get the children initially immunized and we know, based on experiences over the years, that there are certain segments of the population that are very difficult to reach in terms of their access to the delivery of immunization services as well as attitudes toward immunization of the children's parents. The CDC and maternal and child health program are trying to reach these hard to reach groups.

Second is the problem of maintaining immunization status, and this is true not only in low income populations, but in middle class, and upper income groups, unless they regularly visit a pediatrician or other physician. Increasingly individuals are not properly immunized, and there is a problem of the maintenance of an adequate level of immunization. We rely on the individuals themselves to maintain that level.

Part of the work that CDC and the maternal and child health program perform is to educate individuals, the parents, and the school systems that the maintenance of immunization levels is as important as the initial immunization program.

### MCH STAFF SUPPORT

Mr. FLOOD. Since you are still talking about maternal and child health, we keep hearing that the MCH staff has been assigned to other duties. We hear that all of the time. And thus, these projects are not getting adequate technical assistance. What about that?

Dr. VAN HOEK. That is an impression gathered by a number of groups based on the fact that in the 1973 reorganization, the Bureau of Community Health Service went to what we call a functional organization. Although positions are budgeted by specific categorical program activities, staff may be carrying out responsibilities, that it is professionally or technically qualified to carry out, for more than one program and I will give you specific examples.

We have physicians and other health professionals who are extremely knowledgeable about the development and application of health care quality standards. We have other professional staff that are very knowledgeable about health financing and reimbursement. It is believed to be inefficient to have these kinds of skills duplicated in every program, rather, we use these professional and technical skills in all our programs.

Mr. FLOOD. Are the MCH projects getting their own adequate technical assistance?

Dr. VAN. HOEK. We have a system of work planning by which we know the man-years of effort that are devoted to the maternal and child health program, and the man-years devoted to that program are equal to and in some cases exceed the positions appropriated in the budget. We feel the projects are receiving adequate support.

FAMILY PLANNING

Mr. FLOOD. In fiscal 1977 you are proposing to support 2,840 family planning projects. That is 760 fewer projects than you supported in 1976. What is the impact of that reduction, 760?

Dr. VAN HOEK. If that reduction takes place, the impact will be a reduction in the number of individuals served. There will be no reduction in those projects if the block grant proposal with the increased dollars is approved, and if the States continue to maintain the family planning programs as a high priority.

Mr. FLOOD. That's the answer.

Dr. VAN. HOEK. Yes, sir, that's the answer.

Mr. FLOOD. Did you ever do business with States and counties and townships and boroughs yourself at all?

Dr. VAN. HOEK. Not with townships and boroughs, Mr. Chairman, only as a citizen.

FAMILY PLANNING REIMBURSEMENTS

Mr. FLOOD. Now, your budget justification apparently doesn't reflect at all the level of the third party reimbursement here that you expect to collect in 1977. What does that mean—you are just throwing in the sponge, you have given up the idea of collecting any third party reimbursements in this program?

Dr. VAN HOEK. In the family planning program, Mr. Chairman?

Mr. FLOOD. Yes.

Dr. VAN HOEK. Our estimate——

Mr. FLOOD. How much do you expect to collect?

Dr. VAN HOEK. We expect to collect approximately 7 perecnt through third party reimbursement, which is $10.9 million. I would point out that at the current level of operation, the Federal contribution represents 75 percent of the total cost. In other words, 25 percent or more of the program on the average comes from other sources, either third party reimbursement or State and local sharing.

Mr. FLOOD. Now, last year you told us the total HEW expenditure for family planning services in 1976 would be approximately $210 million. Can you give us some idea on how much HEW is going to spend in 1977 under the various programs you have in these services?

Dr. VAN HOEK. The estimate in 1977 is that HEW will spend $232 million for family planning services. This represents the funds that would be incorporated in the block grant under Family Planning—title X Maternal and Child Health—Title V and the programs of the Social and Rehabilitation Services—Titles 19 and 20.

Mr. FLOOD. Suppose you put in the record a table listing all of these HEW programs which support family planning services now, and with that table give us the list of the funding levels for each program for 1975, 1976, and 1977.

[The information follows:]

FUNDING LEVELS, DHEW FAMILY PLANNING SERVICES

[In thousands of dollars]

| Activity | 1975 budget authority | Estimated 1976 | Estimated 1977 |
|---|---|---|---|
| Health Services Administration, Bureau of Community Health Services: [1] | | | |
| Family Planning Service Grants (title X) | $94,500 | $94,500 | $75,135 |
| Maternal and Child Health (title V) | 43,600 | 47,037 | 28,000 |
| Subtotal, BCHS | 138,100 | 141,537 | 103,135 |
| Bureau of Medical Services | 193 | 161 | 172 |
| Indian Health Services | 1,237 | 1,347 | 1,476 |
| Subtotal, HSA | 139,530 | 143,045 | 104,783 |
| Social and Rehabilitation Service: | | | |
| Social Service | 43,177 | 48,400 | 52,800 |
| Medical Assistance | 56,772 | 65,512 | 74,625 |
| Subtotal, SRS | 99,949 | 113,912 | 127,425 |
| Total | 239,479 | 256,957 | 232,208 |

[1] Funds used for family planning services under community health centers, migrant health, and comprehensive health grants to States are not identified.

MIGRANT HEALTH

Mr. FLOOD. Now for the migrant health program, the budget proposes to reduce—boy, you are doing some reducing here—you want to reduce the number of operational projects from 105 to 97. What does that mean? Have you identified another source of support someplace for those eight projects that you are proposing to knock out of the budget?

Dr. VAN HOEK. Several factors need to be considered in answering that question.

Mr. FLOOD. What I asked you is, have you identified other sources of support for the eight projects that you want to get rid of?

Dr. VAN HOEK. First of all, the Department testified to a request for a rescission of the additional funds that would be provided in 1976.

The additional funds that the Congress added to the budget would permit the development and support of seven new centers.

Mr. FLOOD. Did you say rescission?

Dr. VAN HOEK. Yes, sir, in the 1976 budget.

Mr. FLOOD. That's the rescission we took up the other day?

Dr. VAN HOEK. Yes, sir. So that the reduction that you mention in the 1977 estimate is a combination of the action on the proposal for the rescission to not spend all of the additional funds and, therefore, not to support seven new migrant centers, and, in addition, the level of support that is proposed in the 1977 budget. If the Congress does not act favorably on the block grant and the additional funds to be appropriated under the block grant, it would require a reduction in the number of projects, because third party reimbursement cannot be increased significantly beyond what has been achieved at the present time.

IMPACT OF REDUCTION OF MIGRANT PROJECTS

Mr. FLOOD. What will the impact of the elimination of eight of these migrant projects be in the terms of the people now served, in terms of the services rendered and so on?

Dr. VAN HOEK. If such a reduction took place then the number of people served would decline from 400,000 to 350,000 approximately.

Mr. MILLER. Mr. Chairman, I think Dr. van Hoek has clearly described the place of block grants in the development of this budget, but one thing that has not come through clearly is that, at the time this budget was being developed, these reductions you were talking about were not reductions from the base we were considering. We were looking at it before the veto was overridden, before the rescission had been considered. We were looking at a base which was at the level of the original request of the President in fiscal year 1976, and we did not make programmatic judgments that we should have these reductions.

Mr. FLOOD. I will bet you did.

Mr. MILLER. No, no. I mean, if we were guessing what was going to happen, in Congress we would have assumed higher appropriations but in fact we didn't make program judgments that migrant health should be reduced, family planning should be reduced. That is not the policy on which the budget was based. But those reductions are the reality now and we have to cope with them.

MIGRANT THIRD PARTY RATES

Mr. FLOOD. Well, last year you told us these migrant health centers would collect 8 percent from third party sources. What level do you expect to collect in 1977?

Dr. VAN HOEK. The maximum we have been able to achieve under our current estimates is 6 percent, and we don't expect that to increase because there has been no change in some of the requirements in eligibility and financing requirements of the insurance programs which would increase that.

Mr. FLOOD. Well then, put in the record at this point a table showing the total operating budget now of the migrant health projects for fiscal year 1975, 1976, and 1977, and show us the various sources of support.

Dr. VAN HOEK. Yes, sir, Mr. Chairman.

[The information follows:]

MIGRANT HEALTH—TOTAL OPERATING BUDGET

[Dollars in thousands]

| | 1975 | Estimate | |
|---|---|---|---|
| | | 1976 | 1977 |
| Total operating cost | $39,000 | $39,000 | $30,000 |
| Appropriation | 23,700 | 25,000 | 19,200 |
| 3d-party reimbursements | 1,400 | 2,300 | 1,800 |
| Other funds | 13,900 | 11,700 | 9,000 |
| Grantee contribution—In-kind and voluntary services | (12,400) | (10,400) | (8,000) |
| Patient fees | (1,500) | (1,300) | (1,000) |

MIGRANT ENVIRONMENTAL HEALTH

Mr. FLOOD. You recall, Doctor, for the last several years, not just the last year, but the last several years, a great deal of talk about the environmental factors affecting the health status of the migrant workers—sanitation, housing conditions, things like that. What progress have you made in this area and what are your plans for 1977?

Dr. VAN HOEK. We have during the past 2 years, in 1975 and 1976, provided funds to States where there are large populations of migratory farmworkers; the funds are used to develop programs for monitoring and evaluating the environmental factors at the projects, to increase inspections in the labor camps, and to work with State and local agencies in the enforcement of housing, and other environmental codes and regulations. The funds also provide camp aides, outreach workers in the camps to work at sites to help improve the environmental situation.

In addition to that, working with the Center for Disease Control, we have carried out training programs for environmental health project staff.

NATIONAL HEALTH SERVICE CORPS

Mr. FLOOD. Now, on the National Health Service Corps, in your 1977 budget here you propose 676 new assignees. That is 25 fewer than Congress provided in the first supplemental bill for fiscal year 1976. All right now, if we approved this proposal of yours, how many sites would have to close down?

Dr. VAN HOEK. We weren't proposing with our 1977 budget to close any sites, Mr. Chairman. This is tied—the 1977 proposal—to the rescission request on the 1976 budget in which we were proposing not to increase the number of National Health Service Corps assignees until 1977.

Mr. FLOOD. Well, I know, but this program appears to be a terrific success. Everybody says so. All right, will you tell us then if this is such a great success as you say it is, why are you proposing no growth at all in this project?

Dr. VAN HOEK. We are proposing a growth in the program, Mr. Chairman, from the 551 in fiscal 1975 to 676 in fiscal 1977. The only difference is a change in the timing, and the size of expansion.

Mr. FLOOD. It's a no-growth budget, isn't it?

Mr. VAN HOEK. In 1977 as compared to 1975 and the President's 1976 budget, it is an increase.

Mr. FLOOD. If we were going to put back these 25 Corps positions cut out by this budget, how much money do you need for that?

Mr. LITTLE. I am told it is $810,000.

Dr. VAN HOEK. Approximately $810,000. In other words, the President's budget, instead of being $24.5 million, would be roughly $25.3 to $25.5 million.

COORDINATION WITH FOUNDATIONS

Mr. FLOOD. You know about the Robert Wood Johnson Foundation, and we have talked about how they plan to spend $14 million to develop these rural medical projects. Now, since their goals seem to par-

allel your goals, are you working together or competing to see who gets there first, or what?

Dr. VAN HOEK. With your permission, Mr. Chairman, I would like Dr. Martin to answer that question.

Mr. FLOOD. It seems working together you get a much better utilization of all of the resources whatever they are.

Dr. VAN HOEK. The reason I would like Dr. Martin to answer the question is that he is the Chairman of the Rural Health Coordinating Committee for the Public Health Service and, therefore, knows the activities in detail.

Dr. MARTIN. The Robert Wood Johnson Foundations or special rural practice development activities are run by Dr. Don Madison and the National Health Service Corps, and his staff are actively cooperating. There is a clear plan to avoid duplication in any of the areas that are planned for the Johnson Foundation activities. In point of fact, a number of sites that have become independent of the corps are planning to request the Foundation's support. It is important to point out though, their focus is on areas which presently have in many cases higher levels of physicians than practices in the National Health Service Corps. So if it's possible to distinguish between two different levels of need, the programs are possibly going to different places. The Johnson Foundation is interested in certain kinds of communities with a stronger economic base.

Mr. FLOOD. You are not competing?

Dr. MARTIN. No, sir, there is no replication between the two programs.

INDEPENDENT NHSC SITES

Mr. FLOOD. Under the National Health Service Corps., how many have achieved independent or self-supporting status?

Dr. MARTIN. Essentially we have 94 independent practicing communities projected for the end of this fiscal year.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. FLOOD. Doctor, about these HMO's—more alphabet soup—20 percent of the HMO money is for rural projects. How does the National Health Service Corps work with the HMO programs in setting up these rural HMO's?

Dr. MARTIN. Not only in the health maintenance organization program, but in the community health center programs, migrant and maternal and child health programs there are basically identified capacities which are needed in order to build a health system. The first capacity is technology and that is the technical assistance provided most often by Federal employees. Second, dollars and grant project programs like HMO's and communities health centers and the like, and the third is manpower.

About one-third of all the National Health Service Corps assignees in the field now are affiliated or related to the practices and projects or other activities funded by the Public Health Service, like HMO's and community health centers.

RURAL HMO'S

Mr. FLOOD. I am speaking particularly of the HMO's for that reason. What success, if any, is the HMO program having in setting up rural HMO's?

Dr. VAN HOEK. There are difficulties in developing HMO's in rural areas. At the present time, of HMO grants that we have awarded, 18 percent of the grants and 12 percent of the funds have been used to support HMO's in nonmetropolitan areas. Studies have shown what the problems are in developing a health maintenance organization in a rural area. These are the problems of population density; the number of individuals that are potentially a market to be enrolled in HMO; the geographic dispersion phenomenon of developing delivery sites; in essence, decentralized forms for delivery of services by a health maintenance organization and the professional recruitment problems.

Mr. FLOOD. What success are they having?

Dr. VAN HOEK. It's too early to tell with respect to the HMO's that we are supporting in the rural areas. I would point out that an HMO, if it was in a community that was classified as a manpower shortage area, would be eligible to have the assignment of National Health Service Corps staff.

Mr. FLOOD. We know that. We are talking about the success of the thing in the rural areas. What success is the HMO service having in setting up HMO's in rural areas?

Dr. VAN HOEK. There are some HMO's that have been successful in providing services in rural areas. There are also HMO-like organizations—not HMO's as prescribed by legislation—which are primarily independent physician organizations which have been successful in rural areas. I can provide some examples of successful HMO's for the record.

[The information follows:]

Rocky Mountain HMO in Grand Junction, Colo., is an IPA-type nonmetropolitan HMO assisted from the beginning of its development by HEW funding. It is now qualified and serving 9,100 enrolees, of whom 5,000 are medicaid eligibles served under a contract from the State of Colorado.

Operational but nonqualified HMO's in nonmetropolitan areas which have been supported by HEW include Geisinger Health Plan, Danville, Pa. (2,200 enrollees), Mountaineer Health Plan, Beckley, W. Va. (7,200 enrollees). Choice Care, Fort Collins, Mo. (3,250 enrollees), and GHA of northeastern Minnesota, Virginia, Minn. (15,300 enrollees).

Of the 40 developing HMO's in nonmetropolitan areas which are being sponsored under title 13, 5 are already in the initial development stage.

Mr. FLOOD. Apparently HMO's in rural areas, then, are at best a very qualified success. Is that where we are?

Dr. VAN HOEK. It has to be qualified in terms of degree. At the present time, the HMO's are more viable alternatives in a metropolitan area than in a rural area.

Mr. FLOOD. Now, you have all of these regulations finally issued for the HMO program? Do you anticipate any increase in the requests for Federal support?

Dr. VAN HOEK. We are already beginning to find an increased interest, and an intent of more organizations to apply.

Mr. FLOOD. Do you expect to be able to meet the demand to initiate the HMO's with the funds in this budget?

Dr. VAN HOEK. I need to qualify that statement by saying that, at the present time, in the 1976 budget we are not sure the degree to which we may need, or we may be able, to fund all of the HMO's that have been supported.

Mr. FLOOD. You are not sure.

Dr. VAN HOEK. We will be able to tell you later in the fiscal year as to the level of support.

Mr. FLOOD. Do you expect to be able to meet the demand?

Dr. VAN HOEK. At the present time, we are not sure of what the demand will be, and I can't really give you a good hard answer on that now.

END STAGE RENAL DISEASE PROGRAM

Mr. FLOOD. Now, what is the status of the end stage renal disease program? We talked about that earlier; that is, last year. Do you finally have all of the regulations finished and out?

Dr. VAN HOEK. No, sir. The notice of proposed rulemaking was published last fall. There were a large number of comments with regard to those regulations. We have now submitted the latest version of the regulations to the Department for review and approval. We anticipate having them published this spring.

Mr. FLOOD. You have $330 million being spent by SSA in this renal dialysis area. Certainly the implementation of that program will be crucial in light of that $330 million.

Dr. VAN HOEK. The program has been implemented. The regulations are, in effect, completing the initial phase of the requirements under the law. What we have had since 1973 are interim policies. We have placed limitations on the number of dialysis centers and transplantation centers that will be certified and will be reimbursed for providing services. This has controlled the expansion of this costly, highly specialized service, which we have been reimbursing under special reimbursement policies.

END STAGE RENAL DISEASE FUNDING

Mr. FLOOD. Are there sufficient resources now in the budget to move quickly to implement this end stage renal disease program in the budget?

Dr. VAN HOEK. In terms of our administration of the program, Mr. Chairman?

Mr. FLOOD. Resources of any kind to implement the program.

Dr. VAN HOEK. No, sir; the present budget as proposed does not contain sufficient funds.

Mr. FLOOD. I mean to move quickly. Last night.

Dr. VAN HOEK. We do not have the funds and the positions at the present time in the budget to fully implement the end stage renal disease program.

Mr. FLOOD. What additional resources would you need?

Dr. VAN HOEK. Our estimate is that we would need 30 positions and $3.8 million.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION PROGRAM

Mr. FLOOD. Turning now to the professional standard review organization, PSRO's. You want an increase of $14,418,000. That's 30 percent over last year. You have switched hats. Why such an increase? Why is such an increase necessary in light of all of the decreases we have been taking in the other programs?

Dr. VAN HOEK. Because the Department considers the PSRO program to be a very high priority for the following reasons: It is the only mechanism that we currently have available to develop an effective quality review program for the health financing programs under Medicare, Medicaid, and Maternal and Child Health. PSRO expenditures will replace existing DHEW expenditures for utilization review required for medicare and medicaid. Furthermore, we see this as the quality assurance mechanism which is needed if over the next several years some form of national health insurance program is implemented. This is a mechanism by which the professional organizations in effect self regulate the use of health resources and maintain the quality of health care.

PSRO FUNDING

Mr. FLOOD. All right, but isn't this 30 percent increase now in PSRO's only a part of the total increase that this program is going to receive in 1977? How much more will this program receive as the result of these recent Medicare amendments?

Dr. VAN HOEK. In addition to $62 million in this budget, we propose to spend approximately $27 million from the Medicare trust fund account.

Mr. FLOOD. That $27 million gives the PSRO program $89 million.

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. For 1977. That's an increase of 87 percent in 1 year. Now, for you fellows that's substantial considering that the budget calls for reduction after reduction in the direct health service programs.

Dr. VAN HOEK. I need to point out several factors. One is that the budget we presented in 1976 did not show the amount that would be expended from the trust funds for PSRO delegated hospital review. In 1977 this amount is the $27 million that you have mentioned. If you take out this amount to arrive at a figure comparable to the 1976 level, the figure is $62 million. Therefore, the real increase in this budget is $14.4 million.

Second, we need to expand the program as quickly as possible to maintain the support at the professional level for this program. We know of the 55 planning PSRO's that are currently supported, that virtually all of those can be converted by the end of this fiscal year or early fiscal 1977 to conditional status, which means that we can begin immediately to expand hospital review by those PSRO's.

PSRO SAVINGS

Mr. FLOOD. Do you have any data with you or someplace else, showing us the savings from the PSRO activities are going to exceed the level of the PSRO expenditures?

Dr. VAN HOEK. We can provide you with some estimates.
Mr. FLOOD. All right.
[The information follows:]

IMPACT OF PSRO REVIEW

It is clearly too early to assess the true impact of PSRO activities. Very little data is available at present due to the short time that these organizations have been conditional and performing binding review. We can, however, indicate that conditionally designated PSRO's have found evidence that where PSRO review is implemented, hospital lengths of stay are shorter than under previous conditions.

For example, length of stay data available from four newly designated conditional PSRO's (South Carolina, Idaho, Hartford County and Greater Oregon) showed an average decrease of length of stay of 22.75 percent. For medicaid patients, length of stay declined from 7.94 days to 5.68 days. At an average cost of about $100 a day the resultant rough estimate of the saving in basic hospitalization costs was approximately $223 per episode of hospitalization. For medicare patients, length of stay declined from 11.21 to 9.3 days. At a cost of $100 per day, the resultant saving in basic hospitalization costs can be estimated to be approximately $189 per episode of hospitalization.

It should be emphasized that the more startling rate of change for length of stay among new conditionals, 22 percent as compared to 6 percent for the original conditionals, is a function of their state of development. The larger changes in length of stay may be expected when review is first implemented. While we are not certain we can generalize their level of these savings to all 11 million medicare and medicaid admissions we believe PSRO's will function in a most cost effective manner.

In a study performed by the Colorado PSRO of utilization rates in acute care hospitals, adjustments were made in the data to account for a general decrease in utilization rates which is being experienced now throughout the country. The data from the Colorado PSRO, which has been a conditional PSRO since June 1974, was then compared to data from two States (Nebraska and Kansas) where no conditional PSRO's have yet been established. Even though its data had been adjusted, the Colorado PSRO still indicated a decrease in utilization rates.

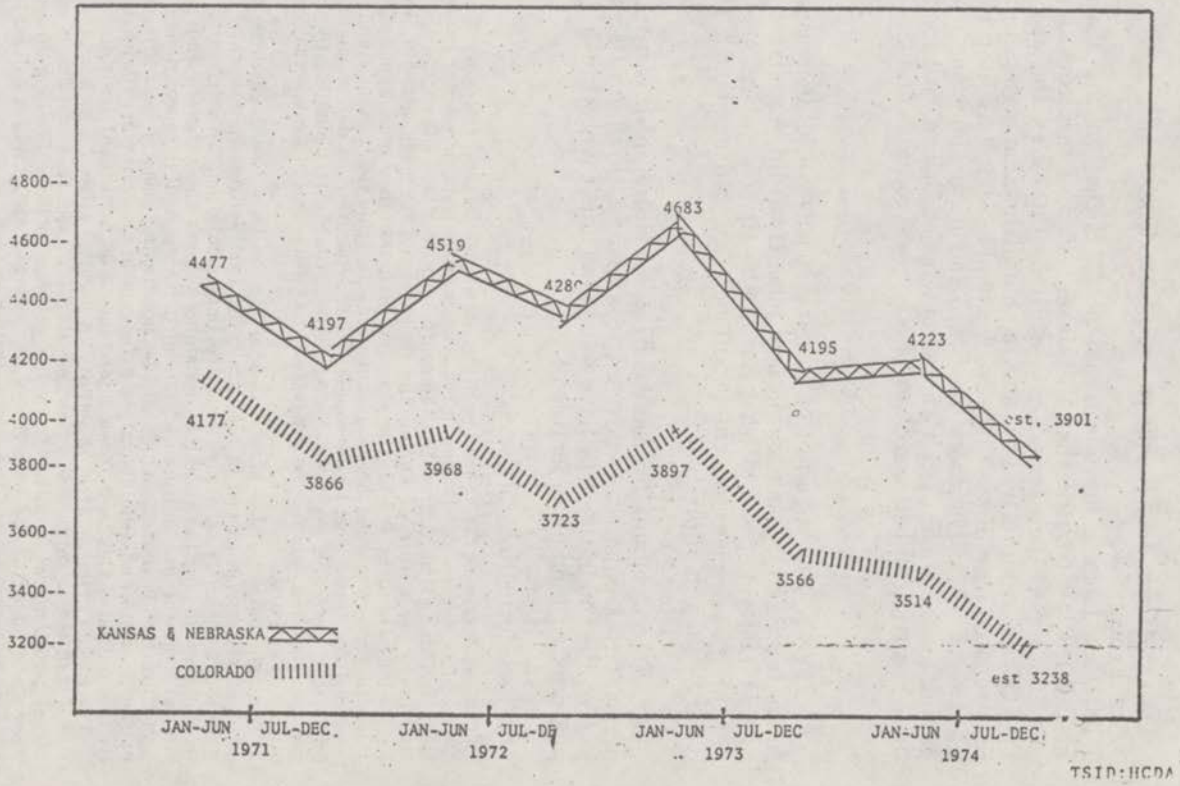
A comparison of data regarding patient days per 1,000 eligibles utilization rate between Colorado and Nebraska and Kansas (States similar to Colorado but with no conditional PSRO's yet) shows quite similar characteristics in seasonality shifts until the first 6 months of 1974, a period which coincides with the current level of implementation in Colorado of PSRO inpatient review. At that point, both Kansas and Nebraska again follow the pattern established in 1972 and 1973 and swing upward while Colorado, unlike its own pattern from the previous 2 years, continues downward.

Colorado continues to increase the gap in patient day utilization rates compared to that of Kansas and Nebraska from 92.4 percent in 1971 to 83.1 percent in 1974. Comparing Nebraska against Kansas shows a relatively constant ratio going from 95.5 percent in 1971 to only 95.6 percent in 1974.

The inpatient charges for each eligible in Colorado compared to Kansas and Nebraska decreased by 10 percent while comparing Kansas with Nebraska indicates an increase of 4 percent. Comparing each group against base year 1971 shows that the 1974 dollar charge per eligible in Colorado increased only 11.1 percent compared to a Kansas and Nebraska aggregate of 21.2 percent.

UTILIZATION RATES

PATIENT DAYS PER 1,000 ELIGIBLES

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UTILIZATION REVIEW ACTIVITIES

Dr. VAN HOEK. May I make one point, Mr. Chairman?

Mr. FLOOD. Yes.

Dr. VAN HOEK. One additional point is that in the absence of PSRO, the law requires that utilization review on medicare and medicaid admissions be carried out in all hospitals. In the absence of PSRO, the hospitals will be carrying out utilization review and under the proposed regulations that review would be almost as comprehensive as under PSRO. Therefore, medicare and medicaid funds would be paying for that review, so it's not a total net additional cost for PSRO, there is a tradeoff between those two review programs and their costs.

NEW POSITIONS

Mr. FLOOD. Now, in addition to the very substantial increases in the funds for PSRO, you want 48 new jobs. How did you arrive at this figure? Did you just pull that out of the air some place, or did you use this "work measurement technique" you told us about? That's a beauty. Did you apply that?

Dr. VAN HOEK. Yes, sir.

Mr. FLOOD. Submit for the record a description of this work measurement technique that you used to arrive at this figure of 48 new jobs so the committee will have some idea how the workload demand justifies that kind of an increase.

Dr. VAN HOEK. Yes, sir.

[The information follows:]

The requirements for 48 new positions as shown in the President's fiscal year 1977 budget were derived through the zero base analysis/manpower management system. This system defines for the central and regional offices the specific activities to be performed during the fiscal year. For each activity, workload projections are identified for the year and predetermined time standards are applied to project staffing needs (manpower) for the year. Time standards are specified for professional and support staff separately to derive staffing needs by type of personnel required. Using this approach, it is possible to arrive at position requirements for the organization as a whole and for specific functional areas and activities.

Through the use of the zero base analysis, we have identified three primary areas of activity described in the fiscal year 1977 budget request which require additional positions to assure effective implementation. The first area relates to the need to provide technical assistance, assess the progress and maintain control over the expenditures of the 83 planning and 120 conditional PSRO's and 10 statewide councils which will be functioning in fiscal year 1977. Analysis of the program and administrative management tasks involved with these activities indicates the need for a minimum of 30 additional positions.

The second primary area of activity in fiscal year 1977 which requires additional staff is long term care review. Analysis indicates that a minimum of 8 additional positions are required to design program policies for long-term-care review and to monitor the activities of the several PSRO's which will be performing long-term-care review on a demonstration basis.

The third primary activity area requiring additional positions in fiscal year 1977 relates to increased workloads in data collection and analysis for monitoring and assessment purposes. A total of 203 PSRO's and 10 statewide councils in fiscal year 1977 will require a minimum of 10 additional positions to perform adequate data collection and analysis.

Thus, a total of 48 positions is being requested in the fiscal year 1977 budget.

HEALTH SERVICES ADMINISTRATION
HEALTH SERVICES

PSRO Zero Base Manpower Analysis
MANPOWER AVAILABILITY VERSUS MANPOWER REQUIREMENTS

Bureau of Quality Assurance

FY 1975 - 1977

| | 1975 | | | | 1976 | | | | | 1977 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MANYEARS AVAILABLE | MANYEARS REQUIRED | DIFFERENCE # | DIFFERENCE % | HSA PROGRAM INCREASE | MANYEARS(est.) AVAILABLE | MANYEARS(est.) REQUIRED | DIFFERENCE # | DIFFERENCE % | HSA PROGRAM INCREASE | MANYEARS(est.) AVAILABLE | MANYEARS(est.) REQUIRED | DIFFERENCE # | DIFFERENCE % |
| PSRO | 155.0 | 162.7 | -7.7 | -5% | 68 | 223.0 | 254.9 | -31.9 | -14% | 50 | 273.0 | 371.0 | -98.0 | -35% |

NOTE: In order to accomplish the projected work load, extensive use will be made of temporary and part-time employment, overtime, both paid and compensatory, reallocate positions from low priority area to high priority area and develop a system of priority program items to be accomplished.

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PUBLIC HEALTH SERVICE HOSPITALS

Mr. FLOOD. And now your budget calls for a legislative proposal to be sent up to the Congress, authorizing the closing of the 8 PHS hospitals. I don't know when Congress is going to act on such a proposal, but we are concerned whether there would be sufficient funds to permit the hospitals to operate, in accordance with the requirements of Public Law 93–155. Will there be? Is there enough money in your budget now to allow you to meet the requirements of Public Law 93–155?

Dr. VAN HOEK. Mr. Chairman——

Mr. FLOOD. Yes, or no.

Dr. VAN HOEK. The answer is no.

Mr. FLOOD. How much more are you going to need?

Dr. VAN HOEK. I gave you an incorrect figure last week, it should have been $22.4 million, not $26 million.

Mr. FLOOD. Don't break down and cry about that, that happens here every hour on the hour.

EMERGENCY MEDICAL SYSTEM

All right. The legislation for your Emergency Medical System expires on the 30th of June, 1976. However, let us take a minute to look at this program. What percentage of the country right now is covered? You have a number on that, haven't you? What percentage?

Dr. VAN HOEK. One-hundred twenty systems out of an estimate of about 300, so it's about one-third.

Mr. FLOOD. What's the impact of these reductions you propose in this budget nationwide?

Dr. VAN HOEK. Mr. Chairman, we are proposing the same level we proposed in 1976 to support this program. The EMS program is part of the block grant proposal, so that the allocation of resources at the State and local level to EMS would be a local decision.

Mr. FLOOD. I have been listening to testimony for a long time and I never heard witnesses with such a beautiful out. Boy, you have got one this year. There is also a lot of concern, as you know, about these operations achieving self-sufficiency. Tell us what is the potential for self-sufficiency? Is this a reasonable goal?

Dr. VAN HOEK. In the Emergency Medical Services System program?

Mr. FLOOD. Yes.

Dr. STREICHER. All of them. The program is a 5-year program.

Mr. FLOOD. That's right.

Dr. STREICHER. It's designed that, at the end of 5 years, these programs would be self-sufficient. So that all of them, if they go the full 5 years, should be then operated by the local governments.

Mr. FLOOD. In addition to the Federal funds that we are talking about for the Emergency Medical Systems, what about the States and private money? How much State and private money has gone into establishing the system?

Dr. VAN HOEK. There are matching requirements.

Mr. FLOOD. I know that, I am asking how much you have got in it, from the State and private sector?

Dr. VAN HOEK. We will have to supply that for the record.

Mr. FLOOD. Also, at the same time for the record identify, now this is very important, identify the areas of the country where we have operational Emergency Medical Systems and the impact that those systems have had to reduce mortality. That's the name of the game.

[The information follows:]

State and Local Funds
for Emergency Medical Services

Information on local funds in many States is not available. However, in several States where Government funds below the State level were identified, the figure is substantial.

| | State | Local |
|---|---|---|
| Alabama | $65,000 | $2,284,600 |
| Alaska | 932,500 | 1,622,280 |
| Arizona | 915,000 | 375,000 |
| Arkansas | 73,408 | 1,462,804 |
| California | 892,666 | 32,318,000 |
| Colorado | 200,000 | 384,000 |
| Connecticut | 343,000 | * |
| Delaware | 22,329 | * |
| District of Columbia | 79,500 | --- |
| Florida | 1,675,000 | 19,098,905 |
| Georgia | 250,000 | 30,000,000 |
| Hawaii | 127,000 | 112,000 |
| Idaho | 149,000 | 760,000 |
| Illinois | 296,000 | * |
| Indiana | 412,030 | * |
| Iowa | 145,000 | 775,000 |
| Kansas | 48,000 | 3,940,000 |
| Kentucky | 1,000,000 | 30,000,000 |
| Louisiana | 410,018 | --- |
| Maine | 100,000 | * |
| Maryland | 2,568,077 | * |
| Massachusetts | 130,000 | * |
| Michigan | 188,000 | * |
| Minnesota | 83,000 | * |
| Mississippi | 34,645 | 15,000,000 |
| Missouri | 596,000 | 2,245,000 |
| Montana | 161,600 | 350,876 |
| Nebraska | 68,700 | * |
| Nevada | 134,572 | 180,500 |
| New Hampshire | $12,012 | * |
| New Jersey | 350,000 | 600,000 |
| New Mexico | 66,795 | * |
| New York | 1,280,000 | 4,000,000 |
| No. Carolina | 2,381,235 | * |
| No. Dakota | 50,500 | 125,672 |
| Ohio | 57,000 | 485,000 |
| Oklahoma | 71,229 | * |
| Oregon | 38,113 | 571,954 |
| Pennsylvania | 800,000 | * |
| Rhode Island | 53,000 | * |
| So. Carolina | 233,032 | 12,500,000 |
| So. Dakota | 49,000 | 89,780 |
| Tennessee | 390,000 | 15,000,000 |
| Texas | 700,000 | 12,000,000 |
| Utah | 88,000 | 71,500 |
| Vermont | --- | * |
| Virginia | 110,000 | * |
| Washington | 348,000 | 2,800,000 |
| West Virginia | * | * |
| Wisconsin | 68,312 | * |
| Wyoming | --- | 92,000 |
| Puerto Rico | 600,000 | 500,000 |
| Total | $19,846,273 | $189,744,871 |

* Data not available.

Impact on Mortality of
Operational Emergency Medical Services Systems
by Critical Patient Category

Trauma (105,000 deaths; 400,000 disabilities annually.)

- Illinois - 29 percent reduction in vehicular accident deaths.
- Maryland - 750 lives saved in the Trauma Center during past year.
- San Antonio - average of one life saved each day.

Cardiac (1.5 million annual cases. 400,000 die within two hours and without medical care.)

- Chicago, Northwest Community Hospital - advanced life support (ALS) system credited with 22 lives saved during 1974.
- Waukegan, Illinois - ALS system credited with 19 lives saved during 1974.
- Nassau County, New York - Decrease in death rate for myocardial infarctions from 5.1 percent to 1.0 percent.
- Seattle - 85 lives saved during past six months. (Extrapolation to the national population would give a potential of 75,000 lives saved each year.)
- Charlottesville, Virginia - 12 lives are being saved annually in the 30-69 age range.

Neonatal (Of 2.5 million annual births, 75,000 are high-risk.)

- Jacksonville - 75 percent survival rate for infants requiring special services.
- Denver - Threefold increase in survival rate of prematures with respiration disorders.
- Temple University - a decrease in infant mortality of 33 percent; San Antonio, 50 percent; and New Jersey, 58 percent.

Poison Control (Of 5 million annual poisoning, 5,000 die.)

- San Diego - Since inception of program, poison admissions have decreased 38 percent.
- Arkansas - During first four months of 1974, 45 life threatening poisonings averted.

Alcohol/Drug Overdose

- Massachusetts - 42 times more alcoholics seek rehabilitative services when acute psychiatric care is available.
- New York City - Threefold reduction in death rate among addicts who participate in methodone drug registry.

Mr. FLOOD. Mr. Michel?
Mr. MICHEL. Thank you, Mr. Chairman.

BLOCK GRANT PROPOSAL

Dr. van Hoek, regarding your block grant proposal, is it accurate to state that if the States make a concerted effort to eliminate waste and excess in the Medicaid program that they could then use these funds to provide greater funding for some of these Health Service programs that would be followed in the block grant?

Dr. VAN HOEK. Not having direct responsibility for the medicaid program, I can't speak to the degree of savings that could be achieved due to increased productivity or better management.

Mr. MICHEL. By public admission some people say there can be 20 percent fraud or overpayments or whatever, so you take the entire cost of the Medicaid program and 20 percent of that is $1.8 billion so there is considerable talk up here on this end of the table I guess about a reduction of some $300 million when actually if under the block grant approach the States could by their own volition eliminate these overpayments, eliminate the fraud, realize the savings, they would have that much more to use to good advantage for whatever health service program they wanted, couldn't they? Isn't that a selling point? Am I way off base or what? You know, I am looking for selling points. Is it or isn't it one?

Dr. VAN HOEK. If there are needs in particular States and localities for improved management and elimination of duplication and so forth, then there are potential savings that can be used to provide services. The other point that could be made is that the block grant provides a mechanism for eliminating duplication of administrative overhead, in terms of multiple agencies, multiple administrative requirements, multiple reporting requirements which are now imposed by programs, as a result of multiple categorical legislation.

STATE FLEXIBILITY

Mr. MICHEL. Would the States have under the block grant approach an unlimited power to move funds from one health service program to another?

Dr. VAN HOEK. Not entirely unlimited, but there are two aspects to that question. One, the block grant is as unrestricted as possible, and second, there is a transition period. Let me give you two specific examples.

Of the total block grant dollars that are allocated to the States, no less than 90 percent of the dollars are to be allocated for personal health service. No less than 5 percent is to be allocated to consumer protection and pubic health types of activities. But within those broad guidelines, the flexibility is pretty much up to the State and the priorities to certain health problems is at the option of the State.

The other provision, which is a transition provision, protects existing programs in the current drafts that we are reviewing. There will be a declining obligation on the part of the States to fund existing projects or programs, beginning with 80 percent the first year, 50 percent the second year, and 25 percent the third year; after that,

the States have a complete option as to continued maintenance of any particular program.

Mr. MICHEL. Have you had any feedback from the States yet on this proposal, whether or not they are, you know, they have had an opportunity yet to comment or to make any points with you?

Dr. VAN HOEK. They have commented on it, on the broad concepts, not the specific legislative proposal, which we have not yet submitted. In the discussions it has been a mixed reaction. There have been State officials and county officials and others who I am told—I have not had direct discussions with them—by departmental staff that they have had favorable reaction to the block grant. Other officials and groups have indicated an unfavorable response, and I don't know the relative proportion of these two views.

STATE HEALTH PRIORITIES

Mr. MICHEL. Now, I think it was Dr. Cooper, last week, said something that State officials have indicated they would allocate their funds for health service programs under different guidelines, or they would have some different priorities if it were up to them.

What, in your judgment, would these different priorities be if the States had the option to go their own route as distinguished from being mandated by the Congress to do it this way?

Dr. VAN HOEK. There are several factors. One has to do with the purpose of the program and the funding. For instance, I would think that the States might well put different priorities on such health problems as maternal and infant care, problems of alcoholism, mental health, and public health.

Mr. MICHEL. Those would increase in priority with the States?

Dr. VAN HOEK. I think it would differ from State to State. We now have programs by which the States get funds by project grant where there is some distortions because urban areas get more than rural areas; in other programs with a formula grant, every State gets a certain amount of money for a certain activity regardless of how much it really needs that money, and those kinds of priorities will change from State to State.

In addition to that, the mechanisms by which the States use the funds may change in that project grants are targeted to support activities by different types of grantees, and the States may switch the grantees and allocate the funds differently than they are currently allocated at the local level.

NHSC FUNDING LEVEL

Mr. MICHEL. I am not sure I understood in that exchange with the chairman on the National Health Service Corps, but we appropriated, I recall, $15 million for the program in fiscal 1976 which was about $2 million over the budget request. You asked for a rescission of that amount over the budget, but then in the fiscal 1977 budget you are asking for an increase of $10 million over the amount we appropriated. Why the rescission if you want more in 1977 anyway?

Dr. VAN HOEK. There is the question of timing in that the increase in 1977 as opposed to 1976 will defer outlays and, therefore, have an impact on Federal expenditures in 1976. Second, the actual level

of increase will be somewhat lower, instead of 701 individuals we are talking about 676 in 1977. So it's 25 positions less and about a million dollars less in the total budgeting for 1977.

NHSC FUNDING AND POSITION LEVELS

Dr. MARTIN. The comparable budget numbers were a $15 million appropriation but in addition to that there was $5 million of fiscal year 1975 money so the effective program cost was $20 million. The National Health Service Corps has a unique problem in that the bulk of the costs are personnel salaries, benefits and travel to get people in and out of shortage areas, so then, when you see changes, it largely reflects the level of salaries per year.

For example, in this fiscal year we actually had on board only somewhere between 500 and 550 people, due to the decision late in May, last year, to go from 405 to 551, which is far too late in the year to recruit enough people. So in point of fact this year we had 50 or 55 less people onboard all year long than we had in our ceiling, and now our plan, of course, is to have 551 people with the related salaries and benefits. The request for 1976 then was for the actual costs of $20 million. If we had everybody onboard that we projected, it would have cost more money but we didn't request the money that we didn't require.

INDEPENDENT NHSC SITES

Mr. MICHEL. What percentage of communities which have been assisted by the Service Corps are now able to support the health professional practice without additional Federal assistance, if any?

Dr. MARTIN. As of June there are 91 practices which have become entirely independent of Federal support. There are about another 140 to 150 practices which pay for the complete support costs, staffing costs, rent, utilities, pharmacy, laboratory, X-ray, other related costs and pay up to 50 to 60 percent of the physician's salary back to the U.S. Treasury. Compared to private practice of medicine with regard to how quickly these community practices make up the income required to run a practice, there is a reasonable comparison. It's important to remember that each year there are essentially 100 to 150 brand-new practices in brand new areas, but as of today, with 504 assignees in the field, there are also 1,400 support staff, nurses, lab technicians and medical technologists that are presently paid for by the community and, in addition to that, all of the rent, utilities, X-ray and lab costs are paid by the community, so if you look at how much it costs to run all of these practices, the Federal Government is paying only 40 to 50 percent and all of the rest is being borne by communities or through the generation of fees by the community practices.

By the end of 2 or 3 years, about 70 to 80 percent of costs of most of those practices will be completely paid for by third party for patients' care. There is a fairly steep rise between the 18th and 36th month. There are exceptions, there are places in this country where the medium income or available income is so low or the population so diffuse that it's impossible to pay for the cost of care, but those represent a minority of sites. The best indicator, of course, is that 91 communities will have full-time practicing professionals totally independent of Federal support by June 30th of this year.

Mr. MICHEL. Could we have those listed in the record?
Dr. MARTIN. Yes, sir.
[The information follows:]

1. NHSC site-independent and recruited on own, MD, DDS, PE (total: 46):

| | |
|---|---|
| Region I | Jackman, Maine, Waterbury, Vt., and Colebrook, N.H. |
| Region II | Barranquitas, P.R., Staten Island, N.Y., Utica, N.Y., Walworth, N.Y., and Bronx, N.Y. |
| Region III | Shamokin, Pa., Smithfield, Pa., Hazelwood/Pittsburgh, Pa., Episcopal/Philadelphia, Pa., Mercy/Pittsburgh, Pa., West Grove, Pa., Community Concern "13" Philadelphia, Pa., Devereaux/Philadelphia, Pa., Muncy Valley, Pa., Shaw/Washington, D.C., Saltville, Va., Bland, Va., Newport News, Va., Drakes Branch, Va., and Pocahontas, Va. |
| Region IV | Cross City, Fla., and Hickory Flats, Miss. |
| Region V | Columbus, Ohio, Kankake, Ill., Hale, Mich., Clinton, Minn., and Waukegan, Ill. |
| Region VII | Loup City, Nebr., North Bend, Nebr., and Haven, Kans. |
| Region VIII | Antonito, Colo., and West Yellowstone, Mont. |
| Region IX | Brentwood, Calif., Casa Grande, Ariz., Phoenix, Ariz., San Francisco, Calif., Union City, Calif., and Rio Linda, Calif. |
| Region X | Oakridge, Oreg., Republic, Wash., Tok, Alaska, Pierce-Wieppe, Idaho, and SIHB, Wash. |

2. NHSC site-independent and NHSC assignee staying private (total: 16):

| | |
|---|---|
| Region I | Windsor, Vt. |
| Region II | Chateaugay, N.Y. |
| Region IV | Frostproof, Fla., Moncks Corner, S.C., Red Bay, Ala., Goodwater, Ala., and Celina, Tenn. |
| Region V | Brownstown, Ind. and Rock Island, Ill. |
| Region VI | Lake Village, Ark. and Louisville, Ark. |
| Region VII | Curtis, Nebr. |
| Region VIII | Hardin, Mont. and Gackle, N. Dak. |
| Region IX | San Jose, Calif. |
| Region X | STOWW, Federal Way, Wash. |

3. NHSC assignee-independently practicing outside Corps site (total: 12):

| | |
|---|---|
| Region I | Lyndonville, Vt. |
| Region II | Montour Falls, N.Y., Utica, N.Y., and Andover, N.Y. |
| Region III | St. Christophers'/Philadelphia, Pa., and Huntington, W. Va. |
| Region VI | Sante Fe, N. Mex., Gallup, N. Mex., Hatch, N. Mex., and Rio Grand City, Tex. |
| Region IX | Hoopa Valley, Calif. |
| Region X | Fossil, Oreg. |

4. NHSC assignee-practicing privately at operational Corps site (total: 3):

| | |
|---|---|
| Region V | Kalmazoo, Mich. |
| Region VI | Tierra Amarilla, N. Mex. |
| Region X | Stevenson, Wash. |

5. Potential assignee who went private at Crops site (total: 14):

| | |
|---|---|
| Region II | Hamilton, N.Y. and Sodus, N.Y. |
| Region V | Warroad, Minn. and St. Helen, Mich. |
| Region VI | Rio Grande City, Tex., Fairfax, Okla., Zapata, Tex., Seiling, Okla., Sulphur, Okla., Claude, Tex., and Denver City, Tex. |
| Region VII | Atkinson, Nebr. |
| Region IX | Winslow, Calif. |
| Region X | Ilwaco, Wash. |

LOCATION OF INDEPENDENT SITES

Mr. MICHEL. Where are those generally? In the big cities?

Dr. MARTIN. They are overwhelmingly rural and, they are fairly well spread across the country, from rural towns in Maine, Alabama, Illinois, and Indiana, and there is a fairly broad distribution across the whole country.

The factors that go into whether a community becomes independent or not essentially develop some practice, are very complicated, and they involve the community itself, what kind of assistance we are able to give, and the doctors we are able to recruit.

There is a fairly broad coverage. But predominantly rural, very few of them are in the inner city, urban areas.

COMMUNITY DEBT REPAYMENT WAIVER

Mr. MICHEL. Now reference is made in the justifications to a new discretionary power that the corps has to waive a site repayment debt incurred during initial operations. Are you planning to become liberal or conservative in your use of that discretionary power?

Dr. MARTIN. We plan to be liberal, but avoiding the use of the way those words are kicked around up here. The purpose of the authority is to relieve communities of debts such that they can go independent more quickly.

For example, if the community board is in the position of owing, let's say, $8,000 or $9,000 to the Federal Government at the end of 2 years, they may choose to extend or request Federal support for an additional year, but if the obligation were waived and the money that they otherwise would have had to pay back could be used to consolidate the practice, it could have gone independent, so if one looks at cost of savings, essentially by waiving an $8,000 or $10,000 debt the community does owe the Federal Government by law, then we save essentially an entire year's salary for the physician and all of the related costs.

The purpose of the waiver is to allow that flexibility for communities to get out from underneath the debt so they can go independent.

Mr. MICHEL. That $3.9 million in collections, does that go directly into the Treasury?

Dr. MARTIN. Yes, sir. It's returned to the Treasury. Remember, we may not use it in any way. That's the fiscal year 1976 projection. It goes into general funds of the Treasury.

STAFFING OF NHSC SITES

Mr. MICHEL. I note you are planning to approve 650 sites in 1977 but that only half of that, well 330 would be staffed.

Dr. MARTIN. The Department's proposal is for 676 positions that would only provide enough staff for about half of the approved communities.

The approval of communities is bound by the law, section 329 of the National Health Service Corps mandates the Department to designate areas that have critical health manpower shortages and that is about 900-plus counties now. The law also requires that any community

may apply for approval of placement of a corps assignee, so basically we must designate the areas and approve them. Then the Department has made an assessment of the appropriate level of positions and dollars which determines to what degree we are going to staff the approved sites.

The determination for fiscal year 1977 is that we will staff about 300 to 330 of these in excess of 600 already approved placements for physicians.

LOAN FORGIVENESS

Dr. VAN HOEK. It's important, Mr. Michel, to point out that a designation is also important to the Bureau of Health Manpower programs in that a physician who agrees to serve in that shortage area can have a loan forgiven, up to 85 percent of his professional education loan, by serving 3 years in that manpower shortage area.

Dr. MARTIN. As either a private physician or as a National Health Service Corps assignee.

Mr. MICHEL. Now, we gave you 140 additional professional people by reprograming, and then the regular bill added 150 more. Do you have a problem recruiting that number?

Dr. MARTIN. No, sir. The additional 146 that were added last year, which took us from 405 to 551 were the ones that were provided in May.

Of that 146 we had recruited about 100 of them already. The actual recruiting cycle begins in October, and essentially the young physicians have made their decisions by January or February, so that the plans for July of this year, essentially at the 700 level approved by Congress, have already been recruited and are in the final processing. If it had been cut back to lower levels, we would have, just like last year, had to tell individuals we cannot possibly put them in the field.

REASONS FOR SUCCESSFUL RECRUITMENT

Mr. MICHEL. How do you account for the fact that you have no problem recruiting when countrywide, you know, you always tallk about the shortage of doctors.

Dr. MARTIN. Three years ago or even 2 years ago I would have sat here and said we had great difficulty recruiting.

I think there are a number of changes enacted by Congress that helped a great deal.

First, the variable incentive pay has helped immensely to recruit physicians, changing salaries from a noncompetitive $18,000 to a competitive level of $31,000.

Second, we have the loan repayment program which pays 60 percent of the loan back for 2 years service, in these areas.

Third is that instead of recruiting physicians to put them in solo percent of the loan back for 2 years service and up to 85 percent for 3 years service, in these areas.

Third, is that instead of recruiting physicians to put them in solo practice, the National Health Service Corps over the last 2 years has been recruiting the physicians to put them in group practices which are consistent with the way young physicians are trained, and by putting

three or four doctors in two county areas you can more easily recruit them.

The last factor is that it requires over the last couple of years a major coordination of the other programs, community health centers, migrant health programs, the rural health initiative, activities in maternal and child health programs. So when you are talking to a young physician about practicng, you are not sticking him solo in a small community. You are talking about putting them in a system where they are not professionally isolated, where consideration is being paid to them and their spouses, and where continuing medical education is available. It's a competitive kind of setting, plus a very aggressive recruitment effort, which we conduct jointy with the Indian Health Service and Federal Hospital Prisons and Coast Guard system. This year we will turn away physicians probably in all of the programs.

DURATION OF CORPS ASSIGNEE'S SERVICE

Mr. MICHEL. How long will these new recruits stay in the Corps?

Dr. MARTIN. Of course, the National Health Service Corps is a little different because we like very much for them to get out of the Corps at the end of 2 years and stay in the community. If you look at the people who came in in 1974 who were due to leave in 1976, about 15 percent of them are staying there in private practice, and an additional 30 percent are staying an additional year to assess whether they want to stay in private practice. That's about half of the total doctors that are either staying in private practice or considering it. The other half leave, but it's important to point out that the one that leave largely are just interns and they just have 1 year of training and they are going back to complete their training. If you look just at board eligible or certified people who have completed their training, it appears to us somewhere between 60 and 80 percent of them will stay.

Mr. FLOOD. Would the gentleman yield?

Mr. MICHEL. Yes.

PARAMEDICAL PERSONNEL IN THE CORPS

Mr. FLOOD. What is your program on paramedics across the board, all kinds?

Dr. MARTIN. The National Health Service Corps is very supportive of using physical extenders, nurse practitioners, and physician assistants.

Mr. FLOOD. How long do they stay around, the paramedics?

Dr. MARTIN. We specifically recruit and train physician extenders from the community. For example, rather than find somebody from a large city and put them in a little town. Our nurse practitioners, for example, are usually local people who are nurses and experienced people and we train them.

Mr. FLOOD. They stay around?

Dr. MARTIN. They stay. Right now the retention rate for physicians' assistants and nurse practitioners is somewhere around 80 or 85 percent. It's their home town so, of course, they will stay. And that's the entire intent of our training and placement activity.

Mr. FLOOD. Yes.

PHS HOSPITALS

Mr. MICHEL. Doctor Cooper indicated that those Public Health Service hospitals are operating at about a 69-percent capacity; how does this compare with say 1973 or maybe 10 years ago?

Dr. VAN HOEK. In fiscal 1973, the workload was slightly greater than this fiscal year. At that time the average daily census was 1,382 patients, and it's currently running about 1,335 for the same 6-month period.

I need to point out that during fiscal 1973 there was an announcement and proposal to close the Public Health Service hospitals and there was a sharp drop in the census after that. Patients began to look for other sources of care; physicians left and we couldn't provide all of the services. During the last 2 years this has again built up and our census now is approaching that of what it was in fiscal 1973.

Dr. STREICHER. That is correct.

Mr. MICHEL. Where did I read this 53 percent of the patients using these hospitals are primary beneficiaries?

Dr. VAN HOEK. That's in our budget justification.

Mr. MILLER. In the Secretary's opening statement, also.

Mr. MICHEL. Of course, that is what the system was principally established for, but it has really become something else since that time.

Dr. VAN HOEK. One has to make a distinction between the primary beneficiaries, who are those listed in the Public Health Service Act as beneficiaries, as opposed to other Federal beneficiaries, whom we call our secondary beneficiaries, active duty military personnel as well as their dependents are eligible for medical care, and other groups.

Mr. MICHEL. They would be counted in the secondary.

Dr. VAN HOEK. They are counted as secondary beneficiaries. In terms of savings to the Government, if they do not receive care in a Public Health Service hospital, they have to be provided care in another uniformed service facility or in the private sector and supported through the CHAMPUS program.

Mr. MICHEL. Can you give us a hard and fast dollar figure if we just close the hospitals, summarily and contracted those very services out? What can we say in dollars and cents we can save or is there a savings?

Dr. VAN HOEK. I will have to give you two different figures. If we deal with all beneficiaries the cost to the Health Services appropriation, of operating the hospital program, as it is currently being operated, would be about $127 million.

If we deal with primary beneficiaries alone, closing the hospitals, providing contract medical care, paying for the termination of Federal employees and so forth, all of those costs and I can give you a detailed breakout, would run about $112 million.

Now that excludes the cost of the Coast Guard medical program, which we are proposing be transferred to the Department of Transportation. So for the Health Services appropriation it's $127 million for all beneficiaries versus $112 for just our primary beneficiaries. However, if we close the hospitals, the beneficiaries of other Federal agencies will now become charged to their appropriations, so there would be a net increase in cost to the appropriations of the Defense Department and other agencies. We can provide those figures for the record as well.

[The information follows:]

PHS PATIENT CARE COSTS WITH CLOSURE OF PHS GENERAL HOSPITALS

This table shows required financing for the Patient Care program in 1977 which would provide inpatient care under contractual arrangements for PHS primary beneficiaries. Excluded are $11,493,000 for Coast Guard beneficiaries who would receive care through the Department of Transportation.

| | *1977 estimated amount* |
|---|---|
| Operation of the National Leprosarium at Carville, La | $7,700,000 |
| Operation of the PHS outpatient clinics for primary beneficiaries | 17,400,000 |
| Ongoing contract care | 11,449,000 |
| New contract care of primary beneficiaries (excluding Coast Guard) | 48,419,000 |
| Personnel separation costs | 18,800,000 |
| Training commitments | 6,494,000 |
| Maintenance of buildings | 1,037,000 |
| Tuskegee, Ala., untreated syphilis program | 1,600,000 |
| Total 1977 requirements | 112,899,000 |

COMPARATIVE ANNUAL COST ESTIMATES OF PATIENT CARE UNDER THE PRESENT PHS HOSPITAL SYSTEM AND CONTRACT/CLOSURE

[In 1975 dollars in thousands, workloads]

| Operating costs | Present system [1] | Contract/ closure [1 2] | Change |
|---|---|---|---|
| 1. BMS primary beneficiaries, leprosy patients, and other hospital operating costs | $78,170 | $78,036 | —$134 |
| 2. Currently not reimbursed: | | | |
| CHAMPUS (HEW eligible) | 4,765 | 7,593 | 2,828 |
| Federal employees' compensation | 3,243 | 6,060 | 2,817 |
| Special Study Patients-HEW supported | 4,396 | 7,380 | 2,984 |
| Subtotal | 12,404 | 21,033 | 8,629 |
| 3. Cost of reimbursable other Federal programs: | | | |
| Indian Health Service | 1,299 | 2,160 | 861 |
| Special Study Patients—HEW agencies | 169 | 284 | 115 |
| Department of Defense—Active duty | 1,388 | 2,443 | 1,055 |
| Department of Defense—CHAMPUS | 19,332 | 30,487 | 11,155 |
| Special Study Patients—Other Federal | 228 | 378 | 150 |
| Other Federal Beneficiaries | 3,873 | 7,092 | 3,219 |
| Subtotal | 26,289 | 42,844 | 16,555 |
| 4. Non-Federal patients: | | | |
| Community and emergency | 4,213 | 7,093 | 2,880 |
| CHAMPUS patients (co-ins. and deduct.) | ------- | 4,231 | 4,231 |
| Foreign seamen | 395 | 659 | 264 |
| Subtotal | 4,608 | 11,983 | 7,375 |
| Total operating costs | 121,471 | 153,896 | 32,425 |
| Depreciation | 2,231 | 816 | —1,415 |
| Total | 123,702 | 154,712 | 31,010 |

[1] Of the total operating cost of $121,000,000 under the present system, over $16,000,000 is received in reimbursements leaving $105,000,000 charged to the PHS hospital appropriation. Of the total operating cost of $154,000,000 under closure, $78,000,000 would be charged to the PHS hospital appropriation.

[2] Assumes that all patients no longer served by the PHS system would instead be served by non-Federal facilities and that none of these patients would be served by DOD or other Federal facilities.

Note: Additional nonrecurring costs under closure not included above: Separation of employees, 1977; $18,800,000. Training commitments: 1977, $6,494,000; 1978, $3,289,000; 1979, $1,794,000; 1980, $368,000. Maintenance of hospital buildings: 1977, $1,037,000; 1978, $1,037,000.

Mr. MICHEL. Is that separation payments, et cetera, then an annual kind of recurring payments?

Dr. VAN HOEK. The termination payments would be non-recurring. The personnel separation costs in the first year would be $18 million.

Mr. MICHEL. But that would not be recurring.

Dr. VAN HOEK. That would not be recurring.

Mr. MICHEL. That is a big significant item of growth to talk to in terms of what is a one-shot proposition, and what is a, you know, a carryover over a period of years, makes a heck of a lot of difference in the ultimate computation.

PSRO'S

Now on these PSRO's, you know, we got on this subject with Dr. Cooper the other day on peer review, and here is another instance of peer review, who picks the peer reviewers.

PSRO AREAS

Dr. VAN HOEK. We have designated throughout the country 203 PSRO areas. That is a geographic area which is based on the practice patterns, the number of physicians practicing in a geographic area, and other factors.

We solicit a proposal from a physician-sponsored organization in that area to apply for planning funds and subsequently for designation as a PSRO. The requirements are that such an organization must have at least 25 percent of the practicing licensed physicians in that area as members of the organization.

In addition, before we designate the conditional PSRO, we publish a notice, and it's made public in the newspapers in the community. If more than 10 percent of the physicians indicate that they are opposed to the designation of that organization, we then have to go to a poll. We poll the physicians through a polling organization, and the majority of the physicians have to approve that organization as their PSRO.

PSRO POLLING RESULTS

Mr. MICHEL. Have there ever been any indications where 10 percent of them have objected?

Dr. GORAN. There have been five times when we have had to go to polling and one poll has been lost out of the five times we have gone to notice.

I would like to return for a second to the question of who picks the peers. The local PSRO picks the peers, and the PSRO staff is responsible for rotating the peer review responsibilities among the physicians in the area who are members of the PSRO Membership is open on a voluntary basis to all physicians in the area. Prior to picking the peers, the PSRO establishes it's own local standards so that when it picks the peers to do the review, they are using standards the members have all agreed upon beforehand.

Mr. MICHEL. Where were those five instances where they actually had a poll?

Dr. GORAN. New Mexico; Sacramento, Calif.; San Mateo, Calif.; Iowa, and Dade-Monroe, Fla., San Mateo lost the poll.

Mr. MICHEL. So what happens in that community?

Dr. GORAN. No conditional PSRO can be designated by the Department, until——

Mr. MICHEL. Is there a period of time, you know, what's the minimum period of time then when you, when it's assumed maybe that another shot would be taken at it?

Dr. GORAN. Prior to the recent amendments to the Social Security Act, the absolute preference to physician sponsored PSRO's was to expire January 1, 1976. At this point the Department was authorized to appoint a nonphysician PSRO. Recent amendments just passed extended physician preference to January 1, 1978, with two exceptions. One exception being in any area where a poll is lost. There is an authority to establish a nonphysician PSRO in these areas. In order to do so, the Department would have to establish regulations defining the qualifications of nonphysician organizations. The other exception applies to any area in which the largest physician membership organization is on record as being opposed to the PSRO program.

STATEWIDE PSRO'S

Mr. MICHEL. You mentioned New Mexico as one of those five. They have a statewide PSRO, correct?

Dr. GORAN. That is correct.

Mr. MICHEL. How many States have a single statewide operation?

Dr. GORAN. Thirty-one currently have statewide PSRO areas. Not all of them have PSRO's. First, we divided the country into 203 areas. We are now, as a result of the new amendments, also in the process of conducting another form of poll in the six States which are currently designated as multiple PSRO area States and have no conditional PSRO's.

Mr. MICHEL. But you have the option under the new law to go statewide?

Dr. GORAN. If they vote this way they will be able to switch to statewide. The poll is taken on an area-by-area basis within the States.

Mr. MICHEL. Do we have any figures, or statistics that would indicate that it is more efficient to operate as a statewide PSRO rather than multiple within the State?

Dr. GORAN. We do not currently have any evidence.

Mr. MICHEL. Or that it's more desirable?

Dr. GORAN. Either way, we have no evidence. There is great variability.

Mr. MICHEL. My home State there for a long time really wanted one statewide, and we have multiples, but, of course, now it will be what, up to a vote?

Dr. GORAN. No. Your State is not eligible for a poll because there is already one conditional PSRO in Illinois in the Joilet area. The poll only applies to those States in which there are no conditional or operational PSRO's established.

Mr. MICHEL. And that is spelled out specifically in the statute?

Dr. GORAN. Yes.

FACTORS CONSIDERED IN DESIGNATING STATEWIDE PSRO'S

Dr. VAN HOEK. I think the critical factors, to go back to the statement about statewide versus local PSRO's, are the number of physicians in the State and the area, the number of hospitals that would be involved and the number of admissions that would be reviewed. It gets to be a massive coordinating problem for a large-scale review program.

Mr. MICHEL. Currently what is the variable there between the low number of hospitals and administrations in a PSRO as against the largest?

PHYSICIANS IN PSRO AREAS

Dr. VAN HOEK. We had an upper limit of 2,500 physicians per area.

Dr. GORAN. Yes, except for metropolitan areas. But the range is from around 300 physicians, the smallest type of PSRO, to about 2,500 to 3,000 for some of the statewides. The metropolitan areas have considerably more than that, but have been retained as single PSRO areas in order to better coordinate with their peers.

PSRO CONFIDENTIALITY POLICY

Mr. MICHEL. All right now, under the authority of the legislation to establish procedures for professional standard reviews, certain Government employees, agencies, and Departments are permitted access to the confidential medical records of any private citizen, regardless of that citizen's dependency or lack thereof of funding. Section 1155(b)(3) and 1155(f)(1)(b) of Public Law 92–603. That is the citation. Now, given the clear congressional intention to safeguard the confidentiality of personal records and documents demonstrated by the passage of the Privacy Act of 1974, could you explain why Government employees, agencies and departments should have access to those most personal of all records of private citizens, medical records, especially those belonging to citizens who receive no Federal assistance?

Dr. GORAN. In developing the confidentiality policies of the PSRO program we tried to take as much cognizance as possible of the Privacy Act and have paralleled the PSRO policies with this legislation. As a result, medical records, records of individual patients are, indeed, protected from everyone except for PSRO reviewers, who themselves may only look at the records in carrying out the review activities for which they have responsibility. And even then the patient must be aware, and be notified that this activity is going on. Federal employees are prohibited from having access to this information.

Mr. MICHEL. So there is a protection and they have to be what, advised of that, of their right to deny?

Dr. GORAN. All PSRO's have responsibilities under the confidentiality policies to alert the patient that they are in the business of doing review, and that this review will periodically require examination of records. The patient is alerted that he may ask the PSRO to see whatever personal information the PSRO has on file about him, much as the Privacy Act outlines.

HMO'S

Mr. MICHEL. Now, a year ago the HMO program was having some problems getting started, and identifying qualified recipients. What has been done to improve that situation?

Dr. VAN HOEK. The most critical element in that delay was in publishing the so-called dual option provisions. This is the provision which requires all employers, who are covered by the Fair Labor Standard Act, to offer a qualified HMO if they have an employee

health benefit plan, and if there is a qualified HMO in their area. With the publication of those regulations we have had significant increase in the number of expressions of interest as well as the number of applicants to be qualified. The stimulus is to market the HMO plan with employee groups. In addition, we have indications that there will be an increase in the number of applicants that wish funds for developmental support and also once they get qualified they are also eligible for HMO loans.

To give you some specific figures, as of the end of the year we had received 104 expressions of interest to apply for qualification. We have qualified 10 HMO's to date under the program. And we anticipate a larger number than that to be qualified within the next 6 months.

Mr. MICHEL. Do you want to list those 10?

Dr. VAN HOEK. Yes.

[The information follows:]

QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS

| *Organization* | *Director* |
|---|---|
| 1. Sound Health Association,[1] 1112 S. Cushman Avenue, Tacoma, Wash. 98405, (206) 572–4800. | Robert E. Huesers. |
| 2. Florida Health Care Plan, Inc.,[1] 305 N. Clude Morris Boulevard, Daytona Beach, Fla. 32104, (904) 255–8451. | Dr. E. D. Davis. |
| 3. North Communities Health Plan, Inc., 1718 Sherman Avenue, Evanston, Ill. 60201, (312) 475–0641. | Mr. Ernest Libman. |
| 4. Piedmont Health Care Corp., P.O. Box 6967, Greenville, S.C. 29606, (803) 233–7437. | Martin Hadelman. |
| 5. Portland Metro Health, Inc., 5201 SW. Westgage Drive, room 111, Portland, Oreg. 97221, (503) 292–9261. | Mr. Paul Vogt. |
| 6. Rhode Island Group Health Association, Inc., 210 High Service Avenue, North Providence, R.I. 02904, (401) 353–4700. | Mr. Kenneth Simmons. |
| 7. Community Health Care Center Plan, Inc., 150 Sargent Drive, New Haven, Conn. 06511, (202) 787–3141. | I. S. Falk. |
| 8. Penn Group Health Plan, Inc., IBM Building, Pittsburgh, Pa. 15222, (412) 391–4980. | Eli Egert, President. |
| 9. Rocky Mountain HMO, Inc., 2525 7th Street, Grand Junction, Colo., 81501. | Mr. Michael Weber. |
| 10. Genessee Valley Group Health Association, 41 Chestnut Street, Rochester, N.Y. 14647, (716) 454–1700. | John Nelson. |

[1] Qualified prior to final 1310 Regulations.

Mr. MICHEL. How much of the HMO allocation is being allocated to make up for the operating losses, on the part of an individual HMO?

Dr. VAN HOEK. The only operating losses that can be supported are the funds awarded through the loan program. The initial operating deficits are only covered by loans to qualified HMO's.

Mr. MICHEL. Why are there those with losses? Is it bad management or what would you attribute it to?

Dr. VAN HOEK. It is not due to bad management. There is a developmental phase of an HMO when it is marketing to individuals and to groups to provide health services, and there is an initial cash flow deficit in that the full level of premiums are not being achieved but

there is a full program already in place, physicians' salaries are being paid, laboratories, contractual arrangements have been developed, and there is an initial cash flow problem of operating deficit which is met by the loan.

Now, both in qualifying the HMO, and awarding the loan, we take that situation into account, and we look at the management of the program, what its operating costs are projected for the next several years, and we evaluate its marketing projections as to how many individuals it estimates it will enroll, and what premiums it will charge. If we find that its overhead or its operating costs are too high or its estimates of income are excessive then, we have turned down HMO's that have requested qualification.

Mr. MICHEL. What is the maximum amount of loan to any one HMO?

Dr. VAN HOEK. $2½ million total and $1 million per year, in any one year.

Mr. MICHEL. And is there no limit on that $1 million per year beyond the initial?

Dr. VAN HOEK. No; the maximum is for 3 years for a total of $2½ million.

Mr. MICHEL. Of those awarded feasibility grants, how many have completed their studies? And then of this number, how many have determined to proceed to develop a qualified HMO? You might just supply that for the record.

[The information follows:]

Of the 108 grantees awarded feasibility studies in fiscal year 1975—
Twenty-two have decided it non-feasible
Eleven have gone from feasibility into planning, and
Seventy-five are still in progress to complete feasibility
For a total of 108.

One of the feasibility grantees has proceeded to become a qualified HMO (Rhode Island Group Health Association).

| *Sponsor type* | | *Sponsor type* | |
|---|---|---|---|
| Physician | 26 | Consumer | 49 |
| Hospital | 19 | Public | 5 |
| Medical school | 2 | Private | 7 |

Mr. MICHEL. Then finally, what types of organizations are sponsoring HMO's, and if you will simply fill out the record with an answer to that question.

And are people actually using these HMO's? Is there underutilization?

[The information follows:]

Sponsoring categories of the 167 projects funded under Public Law 93-222 are as follows:

| | |
|---|---|
| Consumer groups | 74 |
| Public organizations | 6 |
| Hospitals | 23 |
| Physician organizations | 48 |
| Private organizations | 9 |
| Medical schools | 5 |
| Other | 2 |
| Total | 167 |

NOTE.—In most cases people are not actually using these projects since almost all are still in the developing stages and are not yet operational. Among the 10 qualified HMO's that are serving enrollees, there is no evidence of underutilization.

Dr. VAN HOEK. We need to distinguish between HMO's which are the fully qualified HMO's under the act and those which are still in the developmental phase, and those which are HMO-like organizations, which have been in existence for a number of years. There are HMO's that have been in existence, HMO-like organizations, for a number of years that are fully operational and are continuing to expand their programs, to increase their enrollment of individuals in their plans.

In the Public Health Service HMO program itself, a number of the HMO's are still in the developmental phase, and they at the moment have low enrollment and underutilization, but that is a natural progression of the program. The HMO's have a plan to reach a minimal viable operating level in a period of, say, 2 to 3 years.

Mr. MICHEL. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Natcher?

PHS HOSPITAL PATIENT LOAD

Mr. NATCHER. Doctor, I would like to return just for a moment to the Public Health Service hospitals. Is there a sufficient number of beds in each of the eight cities to absorb the patient load, if Congress approved the closing of the hospitals?

Dr. STREICHER. In five out of eight we know for sure there are enough hospital beds in the community.

Dr. VAN HOEK. But, I might add, Mr. Natcher, that we have requested the local and State areawide planning agencies to review the proposals for us, and as part of that review, they will be assessing the availability of beds in the communities to take care of the beneficiaries.

Mr. NATCHER. You say five out of eight. Will you give us the three that you have some doubt about?

Dr. STREICHER. Well, one of the problems you get into, Mr. Natcher, is when you say that five out of eight have enough beds, it's a question of where those beds are. There is no one particular hospital that can absorb the workload for any of the hospitals. It's a question of looking at the total number of beds in the community, the number that are occupied at any one given time, and subtracting that from the total so we find that there may be 300 or 400 or 500 beds in a community, which may encompass the entire city or even go out to the suburbs.

But that means that in any one given hospital there may be only 10 or 15.

Mr. NATCHER. For the record, submit a list of the hospitals located in each of the eight cities showing their current occupancy rate and what the occupancy rate will be if they were to absorb the PHS patients.

Please insert that in the record at this point.

[The information follows:]

Standard Metropolitan Statistical Area

Private Hospital Occupancy Rates
(Short Term General Hospitals)

| PHS Hospital Location | For Year Ending September 30, 1974 1/ | |
|---|---|---|
| | Occupancy Rates | Unoccupied Beds |
| Baltimore | 80.0% | 1704 |
| Boston | 79.5 | 2804 |
| Galveston | 72.0 | 496 |
| New Orleans | 77.6 | 1243 |
| Norfolk | 85.6 | 348 |
| San Francisco | 69.9 | 3977 |
| Seattle | 70.6 | 1338 |
| New York | 83.1 | 7921 |
| Total | 79.5 | 19831 |

1/ Based on latest data available from AHA Annual Survey.

Under the proposed closure plan, primary beneficiaries receiving care at the PHS hospitals would be referred to the community of their residence and/or place of principal employment for inpatient care. Based on a study of listed homes of residence of primary beneficiaries served by PHS hospitals, conducted in September 1975, it is estimated that approximately 21.6 percent of primary beneficiaries live 25 to 100 miles from the hospitals and that an additional 36.8 percent live beyond 100 miles. The table shown below gives a detailed tabulation of this information for each hospital. Since large proportions of our primary beneficiaries are domiciled far from the hospitals, a valid estimate of the impact of hospital closure on local community occupancy rates is not available. This problem is compounded by the fact that responsibility for inpatient care for all non-primary Federal beneficiaries will revert to other Federal institutions or to other contract facilities as determined by the sponsoring Federal agencies. Responsibility for non-beneficiary patients, including community, emergency and special study cases will revert to presently unidentified non-Federal sponsorship.

| PHS Hospital Location | Homes of Residence of Primary Beneficiaries | | |
|---|---|---|---|
| | under 25 miles | 25-100 miles | over 100 miles |
| Baltimore | 26.4% | 7.5% | 66.0% |
| Boston | 34.4 | 46.9 | 18.8 |
| Galveston | 38.5 | 25.6 | 35.9 |
| New Orleans | 26.4 | 30.2 | 43.4 |
| Norfolk | 21.4 | 26.2 | 52.4 |
| San Francisco | 50.0 | 11.5 | 38.5 |
| Seattle | 52.0 | 4.0 | 44.0 |
| Staten Island | 68.5 | 27.2 | 4.3 |
| All Hospitals | 41.6 | 21.6 | 36.8 |

Dr. STREICHER. The impact on any one given community is going to be negligible, because it's our plan not to hospitalize necessarily in the community where the PHS hospital is now open. We are going to hospitalize in the home community of the beneficiary.

HMO'S

Mr. NATCHER. All right, Health Maintenance Organizations, have you funded some that subsequently failed?

Dr. VAN HOEK. Of the 109 feasibility studies that we have supported or 104 feasibility grantees in 1975, we anticipate that 45 will not go on to the planning phase. Now that in itself is not a failure. The feasibility study, in essence, is a study to determine whether the nature of the medical market in that community or area is of such character that it will support a new HMO or that the organizational requirements of the HMO can be met and still be a viable operation. Those 45 organizations will, in effect, be determined as of this year that they will not go beyond feasibility and try and develop an HMO.

Mr. NATCHER. Doctor, have you had any HMO's which reached the operational stage and then failed?

Dr. VAN HOEK. Yes, sir, we have. In the initial program which was supported prior to the enactment of the HMO Act, of the 79 HMO grantees that were supported, only 39 have become operational. There were several HMO's that were planning to become qualified for additional support under the HMO Act, however they subsequently failed, and we can provide the specific numbers for the record for you.

Mr. NATCHER. All right. Suppose we do that.

[The information follows:]

No. None of the 10 HMO's that are now qualified, defined in the act as reaching the operational stage, have failed. In fact, all 10 are meeting their enrollment projections used as a basis for providing them with loan assistance. Of the 79 projects supported in HMO development by DHEW grant funds prior to the HMO Act:

30 are now operational, including 5 which are qualified under the HMO Act.
12 are being supported to complete their development under the HMO Act.
37 have terminated their developmental activities without becoming operational as HMO's.

Of 40 applicants for HMO qualification which have been processed to date, 11 have been qualified and 3 have been rejected. 25 applications are in process and 1 withdrawn.

Mr. NATCHER. Now, of the HMO's that you have supported up through their operational phase, how many have achieved a break-even point, and, therefore, are self-supporting?

Dr. VAN HOEK. I don't have that information, but I will provide it for the record.

[The information follows:]

None of the 10 HMO's supported in their operational phase have achieved a break-even point, because the 3-year period for achieving break-even has not passed for any of them. This is consistent with the projections for break-even in the act.

Mr. NATCHER. I believe at one time, Doctor, as far as a break-even point was considered, we said 30,000 enrollees. Is that the figure that you are still using now?

Dr. VAN HOEK. Yes, sir.

Mr. NATCHER. As I recall it was 30,000.

Dr. VAN HOEK. Roughly 25,000 to 30,000 now.

Mr. NATCHER. And that is this figure, which is a sound figure at this time.

Dr. VAN HOEK. Recent studies have confirmed that the original 25,000 to 30,000 enrollee projection for break-even cannot be uniformly applied to all HMO's. Some HMO's have achieved break-even with under 10,000 enrollees. This will vary according to the organization of the HMO, group practice with significant construction cost or individual practice with little or any construction cost, costs in specific geographic areas, ways in which physicians are organized and compensated, and the manner in which the HMO is managed.

HMO LOAN FUND

Mr. NATCHER. Several years ago, Doctor, we established a $35 million loan fund for HMO's. How many loans have you made from this fund, and have you had any defaults?

Dr. VAN HOEK. To date we have made seven loans in the amount of $8.9 million and we have had no defaults.

Mr. NATCHER. If the HMO should default on its loan, would you have to come back to this committee for an appropriation to cover the default?

Dr. VAN HOEK. No, sir.

Mr. NATCHER. Now, Doctor, what steps are you taking to make sure that there will be no defaults, and thereby avoiding the need to ask this committee for budget authority to cover a defaulted loan? What steps are you taking, if any?

Dr. VAN HOEK. We have several. First, in the initial application for a loan, the HMO must be qualified, and to be qualified it must meet very specific conditions which are specified in regulations.

Second, in reviewing both the qualification application and the loan application, both with our own professional and technical experts, as well as outside consultants, we review the program and its plans. We make site visits to the site, inspect the management processes, the organizational structure, we examine all of the contracts that the HMO is engaged in, we examine the financial accounts and we do an independent assessment of income and cash flow estimates, and the financial plan over several years. If there is any question about the accuracy of the estimates, we query the community resources as to their reliability.

Mr. NATCHER. What about certified public accountants, Doctor, do you ask for any reports from certified public accountants as to the HMO being able to pay back a loan?

Dr. VAN HOEK. In addition to our own financial audit, we require that they set up appropriate accounting systems and auditing procedures so that the continued financial viability of the organization is assured. Then we have a continuing regulation requirement, which will monitor the program annually or on a continuous basis to determine whether the cash flow projections have been met, what the HMO's costs and expenditures are so at an early stage we are alerted to any potential problems that may arise.

PHYSICIAN ENCOUNTER RATES IN CHC

Mr. NATCHER. Doctor, for the Community Health Centers, you said that the primary physician encounter rate will increase from 2.5 to 2.7 encounters per hour. How does that compare to the number of encounters a physician in private practice would schedule for each hour?

Dr. VAN HOEK. Let me have Dr. Martin answer.

Dr. MARTIN. For comparable urban physicians, board certified specialists in pediatrics, internal medicine, OB/EYN, the national range is somewhere between 2.9 to 3.2 so it's a comparable set of figures.

There are figures, however, which indicate that rural general practicing physicians in isolated areas see upward of 4 to 4.5 average per hour, but if you look at the comparable types of physicians, the productivity has increased fairly substantially over the last few years and is reasonably comparable in urban areas to productivities of private physicians.

IMPROVED MANAGEMENT EFFICIENCY

Mr. NATCHER. Doctor, we have heard quite a bit of testimony to the effect that the reductions in the services programs can be partially made up from improved efficiency. I am sure that there is room for improved management, but I doubt that very much of the reduction can be picked up from improved management. Have you conducted a study to determine how much could be saved from improved efficiency and management? Have you done anything along this line, Doctor.

Dr. VAN HOEK. We haven't done a specific study as such overall, but what we have done is we have applied to all of the service projects, particularly community health centers, migrant, and more recently, the family planning program specific productivity measures, looking at staffing patterns, the dollars spent per person or per encounter, and have applied some of these standards to the projects and they are being evaluated against those standards and their performance is being judged against those standards.

We have in the last several years significantly changed the funding levels of some of these projects based on these standards. We will continue to do that.

I would say, in summary, that I think, with the exception of perhaps some selected projects, that overall in the program we have achieved the maximum productivity that can be achieved and also, particularly for community health centers and the migrant health projects, we have achieved the maximum possible in third-party reimbursement. Now, as I say, that's in general. There may be some specific projects or selected locations where there is still room for improvement.

PSRO SUCCESS

Mr. NATCHER. Is the PSRO program a successful operation?

Dr. VAN HOEK. It is still in its early developmental stage but I would say, based on the experience that we have had with the earlier prototype PSRO's and some of the new PSRO's, that they are an effective mechanism for reviewing the quality of medical care. We

will be obtaining data, and we will have more data in the next 6 months to a year which will document the fact that the activities of the PSRO program have a significant impact on utilization of hospitals, shortening length of stay, have an impact on admissions, and as they become fully operational will have an impact on other services provided by physicians and other providers.

We have some anecdotal information, and Dr. Goran can provide that for you and some of the evidence we have to date which shows that impact.

Mr. NATCHER. Go ahead, Doctor.

Dr. GORAN. I think that when we look at PSRO's, we have to realize that we now have 65 organizations doing the review. Most of them have only been conducting the review since July 1975. Therefore the experience is limited in terms of time. Nevertheless we recently conducted an analysis of PSRO performance to try to determine impact. In summary, we tried to look at impact from there standpoints: effect on utilization of health services, quality of health services, and acceptance of the program by the physician, community, and patients.

With respect to utilization, the new PSRO's appear to be having a significant effect on decreasing unnecessary services provided in hospitals. About a 22-percent decrease has been realized in the several PSRO's we have studied. This only applies to a 3-month period, so we doubt we can generalize from it. But if this continues, it is certainly a significant trend. In the older PSRO's that have been in place for some time, they are still maintaining about a 6-percent annual decrease in utilization of services. Looked at another way, for every dollar invested in the review process, from $2 to $3 are being realized in savings by the prevention of unnecessary services.

The quality of care is, of course, much more difficult to measure. But from PSRO's which have been conducting what we call medical evaluation studies or audits to improve the quality of physician practice, we can report that first of all a large number of those audits are being conducted, and the early anecdotal results indicate that selected changes in practical patterns are occurring as a result of these studies. We have some indications of this that we will provide you.

Mr. NATCHER. They will be inserted at this point in the record.

[The information follows:]

MEDICAL CARE EVALUATION STUDIES

We have received some information on medical care evaluation studies which have been conducted by the PSRO's and the effects on institutional care and medical education.

In the San Joaquin Area PSRO, a transfer of medicare patients with tuberculosis to long-term care facilities resulted from concurrent review and criteria development. It was the community practice, while such a patient was in an acute facility, to require three negative cultures before transfer to a long term care facility. However, each culture required 6 weeks with 2-week intervals. Thus, patients would be in an acute facility for about 22 weeks before transfer to a long term care facility. The long term care facilities insisted on this because of fear of losing their licensure and fear of infecting other long term care patients.

The PSRO brought together representatives of the long term care facilities, the County Public Health Department, the acute hospital discharge planners and most important local pulmonary disease specialists. It was generally agreed that no culture was necessary and only two smears were needed, one at the beginning of treatment, and one showing decrease in bacteria count after treatment. Therefore, stays for tuberculosis in acute hospitals have been reduced from 22 weeks to 2 weeks. Further, while some patients go to a long term care facility after 2 weeks, many can be sent directly home on medication.

In the Western Massachusetts PSRO a medical care evaluation study was performed to study the apparent excessive use of antibiotics in patients undergoing vein ligations and stripping for varicose veins. At one hospital, antibiotics were used for this category of patients in 35 percent of the cases during a 1-year period, with a high of 60 percent during the last quarter of 1974. The Professional Activity Study (PAS) norm for this parameter for hospitals in that area was 11 to 27 percent for the same period of time.

Another study included 96 patients with vein ligations and stripping who had been discharged during 1974. The criteria and standards used were established by the Surgical Service on June 7, 1975, and stated that no patient in this category should receive antibiotics, with four specific exceptions.

Analysis of the cases showed that the use of antibiotics was indicated in 22 percent of the cases as compared with their actual usage in 35 percent of the cases. However, further analysis showed that antibiotic usage in two additional cases was justified under exception and that nine other cases would have qualified under exceptions were it not for the fact that antibiotics had not been started preoperatively. Had antibiotics not been used in these 11 cases, the hospital's usage of antibiotics would have fallen below the PAS normative range. This proved that the criteria and standards adopted by the Surgical Service for this parameter were realistic, but that a problem existed in failure to put knowledge into practice. It was recommended that, henceforth, all cases of vein ligations and stripping be monitored during their hospital stay for the appropriateness of antibiotic usage, and that a similar study be repeated for 1975 discharges when data is available.

Other examples of PSRO hospital medical audit activities indicate similar favorable impact on hospital practices and the quality of patient care. As we have indicated, although the value of improved quality of care is more difficult to calculate, it is nevertheless very important. Improved quality can also result in shorter lengths of stay, as well as reductions in inappropriate services. Improved quality also can mean improved health status resulting in reduced need for health services.

A word of caution on expectations of a PSRO's ability to decrease costs. A PSRO is primarily a mechanism for assessing the equality and appropriateness of medical care services which are delivered. Other elements such as financing systems, program coverage decisions and rate-setting mechanisms primarily address cost controls. The quality assurance activities of PSRO's may increase the utilization of some services while decreasing that of others. An effective PSRO program can, however, assure that whatever Federal dollars are spent on health care will only be spent on appropriate quality care.

### PHYSICIAN ACCEPTANCE OF PSRO

Dr. GORAN. Finally, with respect to physician acceptance of this program, it was not clear how rapidly physicians would choose to become members of PSRO's and participate in PSRO peer review. We are now gratified that a third of the physicians in the country belong to PSRO's and in areas where PSRO's have been established about one-half of the eligible physicians are members. Furthermore, we still have 83 areas that do not now have PSRO's which we plan to fill in fiscal year 1977. The other gratifying evidence is that as PSRO's become more mature, as they enter their second and third years of operation, their physician membership acceptance grows remarkably. It takes only 25 percent membership to qualify. But by the second year most of the PSRO's have well over 50 to 90 percent of all the physicians in the area joining them.

### PSRO NATIONWIDE OPERATIONS

Mr. NATCHER. Doctor, do you feel that in certain parts of the country PSRO is a more successful operation than in other sections? What about down my way, Dr. Goran?

Dr. GORAN. I think there is no question that there is a great deal of variability from one part of the country to another. Some of this is historical. The Southwest has begun to demonstrate effective peer review, and as a result of that there are PSRO's doing reviews in these areas. In your State the program is still in the planning stage, attempting to have a reviewing organization designated as a conditional PSRO. From the early information we have, there appears to be more physician resistance in your State than there has been in some of the others. I am not quite sure of the explanation of this. It probably has to do with local factors and the experience of physicians with previous review programs.

So, in summary, there is a good deal of variability. Nevertheless, the 65 PSRO's that are now doing review are widely disbursed throughout the country, and we are going to introduce peer review concepts throughout the Nation. Therefore, we expect it will be easier over the coming years to have PSRO's initiate review activities than it has been in the past.

Mr. NATCHER. Thank you, Doctor.

Thank you, Mr. Chairman.

### HMO REVOLVING FUND

Mr. MICHEL. One question which Mr. Natcher has prompted me to ask. In answer to Mr. Natcher's question with respect to default, you said you wouldn't have to come back to us. Does that mean that the revolving fund would absorb that loss?

Dr. VAN HOEK. The language that we have in our authority is that "Any amounts received by the Secretary in connection with loans and loan guarantees under Title 13, and any other property or assets derived by him from his operation respecting such loan 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 13."

Mr. LITTLE. I am not sure that section permits us to use those funds for defaults. It makes it available to the Secretary for loan and loan guarantees. I believe that the basic HMO Law, Title III of the PHA Act, provides for such authority; however, we will have to check.

Mr. MICHEL. Why don't you clear that up for the record because it's kind of an interesting concept.

[The information follows:]

### HEALTH MAINTENANCE ORGANIZATION

Monies appropriated or deposited to the revolving loan fund are available without restriction for any purpose related to making or guaranteeing loans under title XIII. If there were a default, it could be covered with money in the revolving loan fund. If there were ever insufficient money in the revolving loan fund to cover a default, we could exercise our public debt authority by borrowing from the Federal Treasury. If we ever use our public debt authority, we would then request in our next fiscal year budget an appropriation sufficient to repay principal and interest on the amounts borrowed from the Treasury.

Mr. FLOOD. Mr. Shriver.

COMPREHENSIVE PUBLIC HEALTH GRANTS TO STATES

Mr. SHRIVER. Would you discuss the proposed termination of the 314(d) funds, which are the Comprehensive Public Health Grants to States? Congress funded these grants in 1976 over the administration's veto because we received much support for them from our States.

Dr. VAN HOEK. A block grant is proposed totaling $10 billion to be awarded to States to fund, at their discretion, activities such as those which previously were supported under the Comprehensive Public Health Grants to States program. The President's block grant proposal is, in many ways, an expansion of the 314(d) concept. Until the new overall block grant comes into being, our hope is that the States will pick up and continue the priority activities now being supported by 314(d).

Mr. SHRIVER. The book states that 4 percent of all State health department budgets are supported by these grants. That would vary from State to State, I assume. Do you have figures for individual States? Kansas?

Dr. VAN HOEK. Yes. We have a table on that for the record.

[The information follows:]

Reported State Public Health Agency Expenditures
with Amount and Percent from 314(d) Formula Grant Funds
(Excluding 314(d) Mental Health Expenditures)

Fiscal Year 1974

(in thousands)

| Region & State | Reported State Public Health Agency Expenditures 1/ Total (1) | Amount from 314(d) 2/ (2) | Percent from 314(d) (3) |
|---|---|---|---|
| TOTALS | $2,317,541 | $73,072 | 3.2 |
| REGION I | | | |
| Connecticut | 54,851 | 1,061 | 1.9 |
| Maine | 6,041 | 530 | 8.8 |
| Massachusetts | 67,655 | 1,826 | 2.7 |
| New Hampshire | 5,002 | 484 | 9.7 |
| Rhode Island | 10,875 | 531 | 4.9 |
| Vermont | 4,307 | 431 | 10.0 |
| REGION II | | | |
| New Jersey | 42,352 | 2,177 | 5.1 |
| New York | 182,205 | 5,146 | 2.8 |
| Puerto Rico | 154,312 | 1,697 | 1.1 |
| Virgin Islands | 18,856 | 218 | 1.2 |
| REGION III | | | |
| Delaware | 10,252 | 407 | 4.0 |
| Dist. of Col. | 63,947 | 437 | 0.7 |
| Maryland | 190,148 | 1,324 | 0.7 |
| Pennsylvania | 65,215 | 3,522 | 5.4 |
| Virginia | 58,395 | 1,610 | 2.8 |
| West Virginia | 12,354 | 812 | 6.6 |
| REGION IV | | | |
| Alabama | 19,796 | 1,384 | 7.0 |
| Florida | 73,447 | 2,368 | 3.2 |
| Georgia | 28,092 | 1,510 | 5.4 |
| Kentucky | 63,532 | 1,191 | 1.9 |
| Mississippi | 20,635 | 1,053 | 5.1 |
| North Carolina | 27,534 | 1,982 | 7.2 |
| South Carolina | 32,999 | 1,113 | 3.4 |
| Tennessee | 50,264 | 1,504 | 3.0 |
| REGION V | | | |
| Illinois | 31,829 | 3,193 | 10.0 |
| Indiana | 12,695 | 1,581 | 12.5 |
| Michigan | 64,601 | 2,766 | 4.3 |
| Minnesota | 9,044 | 1,360 | 15.0 |
| Ohio | 30,543 | 3,114 | 10.2 |
| Wisconsin | 12,269 | 1,583 | 13.0 |
| REGION VI | | | |
| Arkansas | 12,216 | 850 | 7.0 |
| Louisiana | 22,075 | 1,331 | 6.0 |
| New Mexico | 5,462 | 597 | 11.0 |
| Oklahoma | 14,603 | 1,065 | 7.3 |
| Texas | 70,964 | 3,357 | 4.7 |
| REGION VII | | | |
| Iowa | 7,069 | 1,072 | 15.2 |
| Kansas | 7,480 | 896 | 12.0 |
| Missouri | 28,494 | 1,646 | 5.8 |
| Nebraska | 5,451 | 662 | 12.1 |

SOURCE: Initial Report on Programs and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974, Appendix Table 9. ASTHO Health Program Reporting System, May 1975.

1/ As reported by State public health agencies to the Association of State and Territorial Health Officers (ASTHO) Health Program Reporting System (HPRS) for Fiscal Year 1974.

The totals do not include local health department expenditures from local funds. Medicaid (7 States) and Special Social (2 States) expenditures are excluded.

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. Does not include expenditures of "15 percent" made available to State mental health authorities from 314(d) funds.

Fiscal Year 1974

| Region & State | Total | Amount from 314(d) 2/ | Percent from 314(d) |
|---|---|---|---|
| REGION VIII | | | |
| Colorado | 15,504 | 926 | 6.0 |
| Montana | 6,168 | 481 | 7.8 |
| North Dakota | 9,256 | 432 | 4.7 |
| South Dakota | 3,667 | 443 | 12.1 |
| Utah | 7,054 | 528 | 7.5 |
| Wyoming | 3,635 | 324 | 8.9 |
| REGION IX | | | |
| American Samoa | 3/ | 3/ | 3/ |
| Arizona | 34,259 | 774 | 2.3 |
| California | 528,577 | 5,739 | 1.1 |
| Guam | 2,679 | 206 | 7.7 |
| Hawaii | 58,868 | 452 | 0.8 |
| Nevada | 4,002 | 388 | 9.7 |
| Trust Territory | 9,717 | 374 | 3.8 |
| REGION X | | | |
| Alaska | 7,424 | 335 | 4.5 |
| Idaho | 2,989 4/ | 154 4/ | 5.2 4/ |
| Oregon | 8,755 | 887 | 10.1 |
| Washington | 17,129 | 1,239 | 7.2 |

3/ Not reported.

4/ $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.

Mr. SHRIVER. If this program were to be terminated, what types of services would that affect? If you can, be more specific than the information on pages 25 and 26. I want to know what, if anything, the people in my State would notice if Congress goes along with your proposal.

Dr. VAN HOEK. The types of services supported with 314(d) funds vary from State to State. For example, funds for personal health services are used for immunizations, dental health, renal disease, and other services while the environmental health category includes such things as air quality, solid waste, and water quality.

In Kansas, per se, 341(d) funds in fiscal year 1974 supported such programs as public health nursing, epidemiology, encephalitis control, TB control, hearing conservation, laboratory diagnostic and surveillance services, and health education. Funds were also available from the State public health agency for most programs which were supported with 314(d) money.

EFFECT OF HEALTH SERVICES ADMINISTRATION'S BUDGET REQUEST

Mr. SHRIVER. In some cases your requests are merely repetitious of the 1976 budget requests which Congress rejected, isn't that correct? The book on page 18 states that these requests are designed to provide "continuity" while the consolidation legislation is being considered. That ignores the fact that we overrode the veto, and these programs are to be operated in 1976 and the transition quarter at a higher level than the 1976 budget requests. Does this mean that you will increase the programs in the remaining months before fiscal 1977 and then phase them back down?

This has an effect on your levels of personnel, too. Will you reach the number of positions called for in our appropriation bill for 1976? If so, would you then drop those people on October 1 if we go along with this request?

Dr. VAN HOEK. You are correct in stating that some of the requests are repetitious of the budget request which Congress rejected. The budget indicates that these requests are to provide "continuity" while consolidation legislation is being considered. This is consistent with the Administration's proposed rescission which is still pending before the Congress. If the rescission is overridden, then the programs will be operating at the higher level to which you refer. Therefore, there will be an increase in the programs during the remaining months of fiscal year 1976 and the transition quarter. However, if the proposed block grant for health passes for fiscal year 1977 we hope that the State and local governments will consider many of these programs to be of high enough priority to allot funds for their continuation so that no reduction in the program level will be required.

The number of positions in the 1976 appropriation bill should be on duty by the end of fiscal year 1976. If you do go along with the 1977 budget request then these positions will be abolished during fiscal year 1977.

OTHER SOURCES OF FUNDING OF BCHS PROGRAMS

Mr. SHRIVER. Would you identify further the receipts and reimbursements which partially fund these programs?

Dr. VAN HOEK. Funds, other than the appropriations, used for projects and/or clinics are: Other grant funds, applicant funds, Title XVIII—Medicare; Title XIX—Medicaid; Title IV–A—Aid to Families With Dependent Children; private insurance, patient fees, foundation grants, State and local public and voluntary cash and in-kind contributions.

PATIENT CARE COST INCREASE

Mr. SHRIVER. You show a sizable increase—$3.7 million—for contract medical care, services, supplies and equipment. Tell us more about that item.

Dr. VAN HOEK. This $3.7 million relates to inflationary costs of operating the PHS hospitals and clinics and of providing medical care of PHS beneficiaries in community hospitals. Primary beneficiaries receive care in these community hospitals under emergency situations or when such care may not be available in PHS facilities. As you know, hospitalization costs are increasing steadily. The PHS hospitals and clinics experience the same inflationary pressures as non-Federal health care providers. This item would help to offset inflation costs of contract health care, medical supplies, food for patients, fuel, and medical equipment.

MCH RESEARCH AND TRAINING

Mr. SHRIVER. There is a reduction of $6.2 million under maternal and child health which would mean phasing out 10 pediatric centers, eliminating five university-affiliated centers and terminating 19 research projects. Have you identified those centers and projects to be ended? Where are they?

Dr. VAN HOEK. Pediatric pulmonary centers could not be continued. The university-affiliated centers could not take the decrease in funding and continue in operation. Therefore it is estimated that five centers would need to be terminated in order to save the remaining 16. We have not identified any program for termination at this time. Every effort will be made to continue as many programs as possible. Those which must be discontinued would be phased out gradually if at all possible. The research program would be curtailed by not funding new proposals and possibly discontinuing some projects now in operation. Specific projects have not been singled out at this time.

REPORT ON MANAGEMENT IMPROVEMENT

Mr. SHRIVER. Has this committee received the report we asked for last year on management improvement and steps you are taking to improve the record of reimbursements from third party sources? Would you comment on that?

Dr. VAN HOEK. No; the committee has not received the report. The draft report has been approved by the Department and it will be available to the committee in the near future.

COMMUNITY HEALTH CENTERS—RURAL HEALTH INITIATIVE

Mr. SHRIVER. Tell us how the rural health initiative program works.

Dr. VAN HOEK. The Bureau of Community Health Services in fiscal year 1975 commenced an administrative effort to develop rural health

delivery systems in communities having the greatest need. The Bureau, through a rural health initiative, integrated the resources of the community health centers program, migrant health program, National health service corps program and the Appalachian Regional Commission to develop 47 projects in rural communities which will provide, through linkages with other health service providers in the area, primary, secondary, and tertiary levels of care. This activity is an effort to improve the delivery in rural communities through administrative action designed to best utilize existing categorical programs administered by the Bureau of Community Health Services.

In fiscal year 1976, the Public Health Service expanded this activity to include all of the health service delivery programs of the Public Health Service. A Rural Health Coordinating Committee, composed of representatives from the Office of the Assistant Secretary for Health, health agencies of the Public Health Service, medical services administration, social and rehabilitation services; and from the Office of Rural Development, Office of the Assistant Secretary for Health, has been established and is providing the direction to coordinate and advise on integrating public health service program efforts in rural areas. Depending on the final availability of funding, as many as 77 projects are expected to be funded in fiscal year 1976. These projects must meet the legislative requirements of the categorical programs from which they are funded. It is anticipated that linkages in these projects will be developed between community health centers, migrant health, Appalachia Regional Commission, National Health Service Corps, alcohol, drug abuse, mental health and area health education centers programs.

NATIONAL HEALTH SERVICE CORPS ASSIGNEE RETENTION RATE

Mr. SHRIVER. What is the retention record of the National Health Service Corps? You might expand on that a bit and tell us what the most serious problems have been and what you are doing to help the situation.

Dr. VAN HOEK. For those corps assignees due to complete a tour of duty June 1976, 43 percent have indicated at this time an intention to extend beyond their original commitment. Extension, however, is still only a temporary phase in the redistribution of personnel providing medical services. Generally, extension leads to a more permanent settling out in an area which is our ultimate goal. That is, we first redress the imbalance in distribution by getting additional provider personnel into shortage areas for an initial corps assignment, then we hope they will either extend or better yet make a more permanent commitment to an area by leaving the Federal service and going into private practice. Our most serious problems have been the availability of personnel who have completed their training through the residency level and thus would not be interested in going back to school for their residency after corps duty, but would be academically ready for private practice. We have engaged in an active program of NHSC advocacy at medical schools and teaching hospitals to attract the more fully trained physicians. In addition we have sponsored sharply focused ads in carefully selected publications which have demonstrated their ability to attract the right kind of applicant. Then we have taken pains to structure the process of matching the applicant

to a community and orienting the applicant and the community to the goal of self-sufficiency so as to minimize those factors which drive providers out of scarcity areas. Finally, we arrange for technical assistance and further professional education and development to support the provider through the difficult first year or two so they feel they can make it in their area as a private practitioner.

### NHSC PHYSICIAN EXTENDERS

Mr. SHRIVER. What is a physician extender?

Dr. VAN HOEK. Physician extenders are health care providers who have had professional experiences in providing for a variety of health care needs, such as nursing, home care, emergency care, battlefield corpsman or medic experiences, public health, and many other types of services, and have subsequently received further education and training in a formalized and recognized program to upgrade or expand upon these skills in order that they may provide a specified level and kind of services. Physician extenders are trained to provide for a level of health care which is more routinized, and for certain kinds of disease processes. Following strict protocols they are able to free up the physicians' time for more serious situations which require a more skilled level of care.

The physician extender may provide diagnosis and treatment. If there is variation from the "norm" when doing a routine examination, such variances are noted and referred to the physician for follow-up. If there is variance from the "normal" progress of a specified disease process, this is also referred to the physician for follow-up.

Physician extenders are able to provide many quality health services in a more efficient manner. The cost of a physician extender/hour is considerably less than a physician/hour without decreasing the quality. A physician who must see all patient problems from the simplest to the most complex may be "hurried" in some aspects of the delivery of health care in order to meet the demand.

### EMERGENCY MEDICAL SERVICES

Mr. SHRIVER. Do you now have legislative authority to award in fiscal 1976 or 1977 any new emergency medical services planning grants or implementation grants? Or training grants?

Dr. VAN HOEK. We do not have legislative authority in fiscal 1976 to award planning grants under section 1202, first year implementation grants under section 1203, or training grants under section 776. However, we do have authority to award second year grants under section 1203 to an entity that received an award under this section in fiscal 1975. In addition, both first and second year grants may be awarded under section 1204. As current legislation expires this fiscal year, there is no existing authority for awarding any grants in fiscal 1977.

Mr. SHRIVER. Along with other Members of Congress, I have received quite a bit of mail in support of the continuation of this particular program. I wonder if you would comment on the long-term goals of the administration in regard to the funding of emergency medical services.

68-650 O - 76 - 9

Dr. VAN HOEK. An administration proposal developed last year, H.R. 7480, would have extended the provisions for planning, initial operations and expansion for 1 year, fiscal year 1977, at an authorization level of $22.6 million. The bill proposes a further extension of the provisions for initial operations and expansion through fiscal year 1978, eliminates the per centum distribution requirements now in the law, and does not provide specific authorities for research or training.

However, we no longer believe categorical authority along the lines of H.R. 7480 is necessary. Therefore, we are proposing to eventually supersede it with the Financial Assistance for Health Care Act which will give States and local governments the discretion to continue funding according to individual State priorities. The Financial Assistance for Health Care Act carries with it a guarantee of funding for grantees who receive Federal support in 1976 under existing categorical legislative authorities. To insure an orderly gradual transition to the block grant program, grantees who receive funds in 1976 would be guaranteed at least 80 percent of their 1976 grant level in the first year, 50 percent in the second year, and 25 percent in the third year.

Mr. SHRIVER. What other agencies and departments are involved in emergency medical services? I know the Department of Transportation has a program. How are the efforts of such agencies coordinated?

Dr. VAN HOEK. The Interagency Committee on Emergency Medical Services has been established to operate in support of the EMS program. Members of this committee coordinate the efforts of the other Federal agencies involved in emergency medical services and are representatives of those same agencies.

Mr. SHRIVER. Would you please present for the record a list of agencies.

Dr. VAN HOEK. I will do that.

[The information follows:]

Federal Representatives:

Department of Transportation
Department of Justice
Department of Defense
Veterans' Administration
National Science Foundation
Federal Communications Commission
National Academy of Sciences
Department of Agriculture
Department of Commerce
Department of Housing and Urban Development
Department of Labor
Department of the Interior
General Services Administration
Office of Telecommunications Policy
National Aeronautics and Space Administration
Appalachian Regional Commission
Department of Health, Education, and Welfare:
Health Services Administration
Health Resources Administration
Alcohol, Drug Abuse, and Mental Health Administration
Food and Drug Administration
Social and Rehabilitation Service
Social Security Administration
National Institutes of Health

Mr. SHRIVER. Has your office been involved in the problem of adequate emergency medical services in the District of Columbia?

Judge Sirica's heart attack and the treatment he did not receive from the ambulance crew brought this to the surface. Each of us is often called on to attend functions in the District, so we have a natural interest in this. Would you comment on the situation?

Dr. VAN HOEK. Yes; we have been involved in this problem with the District. We have been involved directly through the provision of technical assistance to the metropolitan Washington area from both

our regional office and our central office EMS staff and indirectly through a planning grant in Fiscal Year 1974 and an implementation grant in fiscal year 1975, both of which were awarded to the Medical Society of the District of Columbia. Administration of the grant to implement an EMS system in metropolitan Washington was recently transferred to the Council of Government. At this time, everything appears to be progressing satisfactorily.

CRIPPLED CHILDREN'S PROGRAM

Mr. SHRIVER. I notice that under this request Kansas would receive a cut of about $283,000 for crippled children's services. What services would that affect?

Dr. VAN HOEK. There is no information, to my knowledge, reflecting the specific services which would be affected in Kansas.

Mr. SHRIVER. That is a matching program, is it not?

Dr. VAN HOEK. Yes; this is a matching program—1 State dollar to every 2 Federal dollars.

Mr. FLOOD. Mr. Conte.

PRIMARY CARE

Mr. CONTE. What strides have you made this year in increasing primary care to underserved areas?

Dr. VAN HOEK. In 1976, 157 community health centers are providing a range of preventive, therapeutic, and rehabilitation ambulatory services to an estimated 1,500,000 persons. In addition, 372,000 persons are being served in 77 rural health projects which were designed to build health services delivery capacity through the development of an integrated health services delivery system to improve the accessibility, availability and efficiency of ambulatory primary care resources in medically underserved areas. In addition, 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.

Through National Health Service Corps efforts, approximately 852,000 residents of medically underserved areas will be receiving primary care services from Corps assignees located at 340 sites by the end of fiscal year 1976. It is estimated that an additional 300,000 people are receiving services in 91 communities which, through Corps assistance, have developed independent medical care delivery systems. Multiple provider sites are now being stressed rather than solo practices and the rural health initiative has combined existing resources to maximize the overall delivery of primary care services in rural areas.

NATIONAL HEALTH SERVICE CORPS

Mr. CONTE. In your opening statement, you project that 150 National Health Service Corps sites will have become independent. When do you feel this will come about and how do you define "independent"?

Dr. VAN HOEK. At the present time 91 sites have become independent since the National Health Service Corps began operations. We anticipate that by June 30, 1977, about 55 more sites would become independent for a total of about 150. "Independent" means: (a) a former

Corps assignee enters private practice in the same area to which he was assigned; (b) a Corps site that had a Corps assignee who left but whose practice was picked up by a private practitioner who moved to the area; and (c) a Corps site that never had a Corps assignee on duty but to which a private practitioner came, because of the development activities initiated and sponsored by the Corps.

EMERGENCY MEDICAL SERVICES

Mr. CONTE. The emergency medical service programs in my district are doing a really outstanding job. I would like to see expansion of this program. Illinois has seen a 20-percent decrease in vehicular deaths; in Seattle 85 lives were saved in 6 months just from cardiac problems. With this kind of success you are reducing dollar amount by $11,925,000 and funding only 4 new starts as opposed to 47 last year. How do you justify this?

Dr. VAN HOEK. We feel that this program has successfully demonstrated emergency medical service techniques to local communities and has resulted in substantial numbers of lives saved. We further believe that the President's budget contains adequate funds to carry out this demonstration effort.

REDUCTION IN NUMBER OF COMMUNITY HEALTH CENTERS

Mr. CONTE. I notice on the chart on page 23 that the total project level has dropped from 234 to 137 community health centers. Can you detail for us what happened to the 97 that are no longer there?

Dr. VAN HOEK. The 1977 budget request for Community Health Centers reflects a 20 percent reduction in grant funds from a base of $196,648,000 in fiscal year 1975. We project that this reduction will require termination of support to 77 rural health initiative projects and 20 community health centers. These 97 projects which may be terminated will have to seek funding support from State and local authorities or from private sources.

CHC THIRD-PARTY RECEIPTS

Mr. CONTE. Also on the table on page 23 it indicates that although cost per person served will go from $105 to $119, third-party receipts will drop over $11 million. Why such a significant drop?

Dr. VAN HOEK. Based on actual funding in fiscal year 1975 of community health centers, 69 percent of the total operating costs were supported by grant funds, while approximately 20 percent of total operating costs represented actual third-part reimbursements and the remaining 11 percent came from all other non-Federal funding sources including State/local contributions. Through a recent survey it was determined that the maximum potential of third-party payment as a percentage of the total operating cost is 22 percent. Therefore, in fiscal year 1976 and fiscal year 1977, Community Health Centers will be required to maximize third-party payments. Since the fiscal year 1977 budget request reflects a 20 percent reduction in grant funds from the 1975 budget base, a reduction in the number of projects and people served is required; therefore a proportionate reduction will also occur in third-party reimbursement from approximately $65 million in 1976 to $54 million in 1977, a drop of approximately $11 million.

SUDDEN INFANT DEATH SYNDROME

Mr. CONTE. Last year I worked hard to get adequate funding for sudden infant death syndrome work and here you request that we knock it out totally: Why?

Dr. VAN HOEK. We do not believe this program should be discontinued. There is the possibility of the SIDS projects becoming a part of the ongoing Maternal and Child Health program, particularly in States where the projects are already administered by the State. Where this occurs it would cause other activities of lesser importance to be curtailed. The block grant approach may help the States in achieving the flexibility needed to make such program decisions.

MATERNAL AND CHILD HEALTH GRANTS TO STATES

Mr. CONTE. Does the $101,778,000 decrease in grants to States under Maternal and Child Health include the loss due to inflation?

Dr. VAN HOEK. The $101,778,000 decrease does not include an inflation factor.

CRIPPLED CHILDREN'S PROGRAM

Mr. CONTE. What was the reasoning behind hitting the crippled children's program so hard? I believe these services will be reduced about 30 percent.

Dr. VAN HOEK. Crippled children's programs are operating at full financial capacity. The estimated 30 percent reduction in services is the reflection of the general limitation of funds requested. The crippled children's program is receiving a proportionate share of the funds available. There are several options States may take to meet this generalized limitation: (1) they may limit the number of admissions to the program; (2) they may be selective in the types of diagnostic conditions they serve, thus considering conditions which require extended care; and (3) they may consider maximum dollar ceilings on services to individual patients. None of these options allow maximum services to all in need. They are only alternative ways of meeting the financial problems before us.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. CONTE. On page 37 you indicate that the request will eventually generate 50 HMO's which have the potential of serving 1,500,000 enrollees. How was the 50 number arrived at?

Dr. COOPER. Entities that have progressed to the planning or initial development stage are assumed to have 90 percent probability of becoming operational HMO's. Therefore, the 39 planning and initial development grantees plus the 14 operational projects receiving loans should produce approximately 50 health maintenance organizations.

NHSC PHYSICIAN RETENTION RATE

Mr. CONTE. What is the present retention rate in the National Health Service Corps?

Dr. VAN HOEK. For those Corps assignees due to complete a tour of duty June 1976, 43 percent have indicated at this time an intention to extend beyond their original commitment.

Mr. CONTE. How much do you feel you can improve this rate?

Dr. VAN HOEK. The Corps in the past year has been able to attract a much higher percentage of physician assignees who have completed residency level training. For those starting in July 1976, this will be nearly 80 percent of those starting as contrasted to less than 20 percent a few years ago. Since completion of training is a critical factor affecting retention and those who have such training are more likely to stay in an area, we feel that the retention rate and independence rate will continue to improve. We feel it reasonable to expect that retention could improve to at least a 65 percent proportion and perhaps even 75 percent. Given that as a Nation about one household in five moves in any year, we feel that a 75 percent retention rate is a probable maximum figure.

PHYSICIAN EXTENDERS

Mr. CONTE. Can you tell us a little about "physician extenders" and why you plan to increase them while decreasing dentists and physicians?

Dr. VAN HOEK. Physician extenders are health care providers who have had professional experiences in providing for a variety of health care needs, such as nursing, home care, emergency care, battlefield corpsman or medic experiences, public health, and other types of services, and have subsequently received further education and training in a formalized and recognized program to upgrade or expand upon these skills in order that they may provide a specified level and kind of services. Physician extenders are trained to provide for a level of health care which is more routinized, and for certain kinds of disease processes. Following strict protocols they are able to free up the physicians' time for more serious situations which require a more skilled level of care.

The physician extender may provide diagnosis and treatment. If there is variation from the "norm" when doing a routine examination, such variances are noted and referred to the physician for followup. If there is variance from the "normal" progress of specified disease process, this is also referred to the physician for followup.

Physician extenders are able to provide many quality health services in a more efficient manner. The cost of a physician extender/hour is considerably less than a physician/hour without decreasing the quality. A physician who must see all patient problems from the simplest to the most complex may be "hurried" in some aspects of the delivery of health care in order to meet the demand. The current trend for practice settings is away from solo practice toward partnerships and organized group practices. However, many of the medically underserved areas are not capable of sustaining solo practices, let alone larger groups. While the utilization of a physician extender as a team member in the delivery of health services may not be the perfect or final answer, it does present another alternative or a progression in the development of health care delivery to medically underserved areas. Since these small practices are effectively linked into a more comprehensive system of health care delivery, they are able to provide high quality service to an underserved area in an efficient manner. The most efficient practice model according to recent Corps experience data is a single physician with a single extender. This combination has

a lower total cost per (equivalent) unit of service over time than any other combination of two or more physicians with or without extenders. Therefore we are expanding the percentage of physician extenders so we will better able to serve the smaller communities that cannot support a larger medical unit in residence.

HOME HEALTH SERVICES AND HEMOPHILIA PROGRAMS

Mr. CONTE. This subcommittee has consistently indicated its support for the home health services and hemophilia programs, yet you are again proposing elimination of this funding item. Is it the policy at HEW that these are not worthwhile programs.

Dr. VAN HOEK. No. It is not the policy at HEW that home health services and hemophilia programs are not worthwhile. However, we are faced with the problem of making hard choices in a time of fiscal constraint. We know that there are currently over 2,200 home health agencies in existence and reimbursement for the cost of many of the home health services they provide is paid from medicare and medicaid funds. In the area of hemophilia, a number of service programs are sponsored by State and local agencies, many of which receive support from maternal and child health project. Thus, these two areas of concern are already receiving attention, and a significant level of Federal resources is already being applied in support of home health and hemophilia activities. It is our judgment that although these programs are worthwhile, they do not warrant additional health funds during this critical fiscal period.

MIGRANT HEALTH

Mr. CONTE. What is the estimated number of persons to be served in fiscal year 1977 by the migrant health projects?

Dr. VAN HOEK. Based on the President's budget of $19,200,000 it is estimated that 353,000 persons will be served.

Mr. CONTE. How does this compare with the total need for migrant health care?

Dr. VAN HOEK. 3,000,000 migrant and seasonal farmworkers comprise the eligible target population. Services to 353,000 persons would mean that we are reaching about 12 percent of those eligible.

FAMILY PLANNING

Mr. CONTE. The chart on page 32 indicates that the number of patient medical visits is expected to drop off by almost 1 million. I take it that the decrease is due to lack of funding rather than lack of demand for the services. Is that not correct?

Dr. VAN HOEK. Yes, that is correct. We do not anticipate any decrease in the demand for services. However, if the State and local levels determine family planning is of significant priority there will be no reduction of medical visits.

NURSING HOME ACTIVITIES

Mr. CONTE. I am still getting reports about the quality of care in nursing homes being terrible. What, if anything, has the Bureau of Quality Assurance done in the past year to correct this?

Dr. VAN HOEK. The Office of Nursing Home Affairs has prime responsibility for the assessment, refinement, and development of more effective health and safety standards for long-term care facilities. The Bureau of Quality Assurance assists with those responsibilities.

The Bureau of Quality Assurance has launched an accelerated training program for surveyors of long-term care facilities to improve their ability to (1) detect quality of care problems, and (2) assist nursing homes to correct deficiencies. In addition, surveyor training manuals have been produced and distributed by the Bureau of Quality Assurance staff. Also, regional staff partcipate in validation surveys to long-term care provides in collaboration with regional office of Long-Term Care Standards Enforcement staff.

Another activity geared toward improving surveyor performance, is an evaluation program designed to identify surveyors' job performance criteria and to set out training programs needed to improve specific surveyor performance inadequacies.

The Bureau of Quality Assurance had a major role in the development of the recently revised utilization review regulations and guidelines applicable to skilled nursing and intermediate care facilities. These regulations were published in the November 29, 1974 Federal Register and became effective on July 1, 1975. The purpose of these regulations is to improve the utilization and quality of medical and health services so as to assure that such services are provided only when medically necessary and are of optimum quality. The Bureau of Quality Assurance continues to work in concert with the Office of Nursing Home Affairs, Social and Rehabilitation Services and Social Security Administration to effect full implementation of effective and efficient review systems.

Under the Professional Standards Review Organization program, the locus of responsibility for the review of appropriate utilization and quality of health care rendered to Federal beneficiaries shifts from individual facilities to the Professional Standards Review Organization. During the past year, the Bureau of Quality Assurances has been working closely with several Professional Standards Review Organizations to develop approaches to Professional Standards Review Organization review of long-term care services. There has been insufficient time to measure the impact of Professional Standards Review Organization review on the utilization of services and quality of care in long-term care facilities. Over the next 2 years increased emphasis will be placed on Professional Standards Review Organization long-term care review, and, consequently, the Bureau of Quality Assurance will be evaluating the impact of such review in a systematic manner with the assistance of experts in the long-term care field.

Mr. CONTE. Will they continue to be funded adequately so that they can keep an eye on the problem?

Dr. VAN HOEK. The Bureau of Quality Assurance will carefully assess current and proposed Professional Standards Review Organization long-term care review programs to enable us to fund implementation of those review programs with the greatest potential for impact on improving utilization and quality of services in long-term care facilities. In addition, the Bureau of Quality Assurance expects to award a contract for purposes of implementing long-term care review demonstration programs and to assess their overall impact.

COMMUNITY HEALTH CENTERS/MEDICALLY UNDERSERVED AREAS

Mr. CONTE. How many of the community health centers are currently operating in medically underserved areas?

Dr. VAN HOEK. To date there are 234 community health centers, of which 110 projects serve urban populations and 124 serve rural communities in medically underserved areas of 41 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

MATERNAL AND CHILD HEALTH RESEARCH

Mr. CONTE. Will any ongoing research efforts in the maternal and child health program be curtailed due to the funding level?

Dr. VAN HOEK. The research effort would be curtailed in this fashion. No new research proposals would be funded. Projects will be individually reviewed and those which show the greatest potential would be given high priority. Projects nearing completion would be continued because of the investment of time and money already in the projects.

Mr. FLOOD. We will adjourn.

# JUSTIFICATION OF THE BUDGET ESTIMATES

1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES ADMINISTRATION

Health Services


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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 titles V and XI of the Social Security Act [$557,693,000] *$697,187,000*, 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 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 of the estimated cost shall be made by way of reimbursement or in advance to this appropriation: *Provided further*, That in addition, [$26,671,000] *$39,121,000* may be transferred to this appropriation as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein.

4

[For an additional amount for "Health services" for carrying out, to the extent not otherwise provided, titles III, X, and part D of title XI of the Public Health Service Act and sections 602, 604, and 605 of Public Law 94-63, $437,013,000.]

Explanation of Language Changes

1/ Authority under Title X of the Public Health Service Act had expired at the end of 1975 and was not extended until too late to be included in the Conference Bill. However, funds were made available under the extended authority in the Supplemental Appropriation.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES ADMINISTRATION

Health Services

Amounts Available for Obligation 1/

| | 1976 2/ | 1977 |
|---|---|---|
| Appropriation | --- | $697,187,000 |
| Enacted supplemental appropriation | 437,013,000 | --- |
| Conference Action | 561,093,000 | --- |
| Subtotal, adjusted appropriation | 998,106,000 | 697,187,000 |
| Comparative transfers to: | | |
| "Department of Transportation": for transfer of Coast Guard medical services program | -8,498,000 | |
| "General Departmental Management": for the transfer of long-term care and related Title XVIII activities | -350,000 | |
| "Office of the Assistant Secretary for Health": to support the establishment of safety management function in the regional offices | -23,000 | |
| "General Departmental Management": for the transfer of budget services to the regions | -7,000 | |
| Comparative transfers from: | | |
| "Indian Health Services": to support decentralization of Parklawn personnel office | +61,000 | |
| Receipts and reimbursements from: | | |
| "Federal funds" | 24,842,000 | 25,076,000 |
| "Trust funds" | 26,671,000 | 39,121,000 |
| "Non-Federal funds" | 1,274,000 | 1,217,000 |
| Unobligated balance, start of year | 21,134,000 | 1,592,000 |
| Unobligated balance, end of year | -1,592,000 | -1,592,000 |
| Total, obligations | 1,061,618,000 | 762,601,000 |

1/ Excludes the following amount for reimbursable activities carried out by this account: 1976-$6,946,000 and 36 positions; 1977-$6,854,000 and 36 positions.

2/ Includes $103,159,000 proposed for rescission in Presidential message.

Summary of Changes

| | |
|---|---|
| 1976 Estimated obligations | $1,061,618,000 |
| 1977 Estimated obligations | 762,601,000 |
| Net change | -299,017,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. 1976 Annualization of October 1975 pay raise | --- | 8,643,000 | --- | +1,780,000 |
| 2. Annualization of 150 new positions authorized in 1976 | 150 | 2,471,000 | --- | +2,471,000 |
| 3. Within grade and longevity increases | --- | 99,681,000 | --- | +2,722,000 |
| 4. Increase in employee benefits | --- | | --- | +37,000 |
| 5. Increase for DHEW Working Capital Fund | --- | 1,211,000 | --- | +271,000 |
| 6. Increase for HSA Service and Supply Fund | --- | 856,000 | --- | +157,000 |
| 7. Increase for Federal Telecommunications System | --- | 1,138,000 | --- | +140,000 |
| 8. Increase for Bureau of Employee compensation | --- | | --- | +82,000 |
| 9. Increased rates for postage, utilities and miscellaneous rates | --- | 6,070,000 | --- | +551,000 |
| 10. Increases for contract medical care, services, supplies and equipment | --- | 42,983,000 | --- | +3,738,000 |
| 11. Increased cost of operations of reimbursable health units | --- | 6,224,000 | --- | +177,000 |
| Subtotal | | | | +12,126,000 |
| B. Program: | | | | |
| Community health services: (a) National health service corps - $1,800,000 to fund 50 previously unfilled 1976 positions at full-year cost to serve 75,000 additional people and $910,000 to replace 72 interns with board eligible physicians to increase retention (18% to 45%) | 701 | 20,000,000 | --- | +2,710,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Quality assurance: | | | | |
| (b) Professional standards review organizations - increase will provide for 48 positions and related costs of $650,000; allow for 83 new planning PSROs; and 4 new State councils ..... | 173 | 47,582,000 | +48 | +14,220,000 |
| Program management - support expansion of Corps field sites..... | 941 | 30,663,000 | +10 | +200,000 |
| Subtotal..... | | | +58 | +17,130,000 |
| Total increases ..... | | | +58 | +29,256,000 |
| Decreases: | | | | |
| A. Built-in: | | | | |
| 1. One day less pay..... | --- | | --- | -286,000 |
| 2. PHS hospital repair and modernization projects-non-recurring..... | --- | 13,815,000 | --- | -13,815,000 |
| 3. Termination of funding for EMS research grants -authorization expires. | --- | 3,925,000 | --- | -3,925,000 |
| Subtotal..... | | | --- | -18,026,000 |
| B. Program: | | | | |
| Community health services: | | | | |
| (a) Community health centers - reduction of 97 projects of 234 and a reduction of 564,000 people served..... | --- | 196,648,000 | --- | -41,458,000 |
| (b) Comprehensive health grants to States-elimination of program.. | 63 | 90,000,000 | -63 | -90,000,000 |
| (c) Maternal and child health | | | | |
| (1) Grants to States-eliminates 75 of 280 program of projects and a reduction of 30% of people served | 58 | 295,700,000 | --- | -101,778,000 |

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| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| (2) SIDS - elimination of program..... | 10 | 2,500,000 | --- | -2,500,000 |
| (3) Research and training - Phase out of 10 pediatric centers; eliminates 5 University affiliated centers and terminates 19 of 93 research projects... | --- | 23,708,000 | --- | -6,208,000 |
| (d) Family planning - terminates 760 clinics of 3,600 and reduces 451,000 persons from 2,200,000... | --- | 100,615,000 | --- | -21,180,000 |
| (e) Migrant health - elimination of 8 operational projects from 105 and 7 developmental projects resulting in a reduction of services to 46,000 persons from 399,000..... | --- | 25,000,000 | --- | -5,800,000 |
| (f) Health maintenance organizations: | | | | |
| (1) Grants and contracts-Reduction in obligations of funding for rural HMOs..... | --- | 15,727,000 | --- | -727,000 |
| (2) Program support-Absorption of mandatories results in a reduction of 8 manyears..... | 129 | 3,612,000 | --- | -187,000 |
| (g) National health service corps-Reduction of 25 positions providing services to 31,500 people and 10 communities.. | 701 | 20,000,000 | -25 | -825,000 |
| (h) Hypertension - elimination of program..... | --- | 3,750,000 | --- | -3,750,000 |
| (i) Home health services - elimination of program.. | --- | 3,000,000 | --- | -3,000,000 |
| (j) Hemophilia - elimination of program..... | --- | 3,000,000 | --- | -3,000,000 |
| Quality assurance: | | | | |
| (a) Medical care standards-decrease for ESRD activities; including the Medical Information Center, and absorption of $112,000 for mandatories resulting in a reduction of project contracts and other services..... | 170 | 5,187,000 | --- | -1,112,000 |

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| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Patient care and special health services: | | | | |
| (a) Patient care - closure or transfer to community use of 8 hospitals | 5,479 | 136,056,000 | -566 | -18,290,000 |
| (b) Federal employee health- Reduction in cost of administrative program | 267 | 6,830,000 | --- | -32,000 |
| Emergency medical services- Reduction in grants for development of EMS systems | --- | 33,100,000 | --- | -8,000,000 |
| Program management- Absorption of mandatories results in a decrease of $940,000 and 43 manyears; $355,000 for project contracts for Community Health Center program improvement activities; $230,000 for other services for the Bureau of Medical Services; and $875,000 for rental payments to GSA | 941 | 30,663,000 | --- | -2,400,000 |
| Subtotal | | | -654 | -310,247,000 |
| Total decreases | | | -654 | -328,273,000 |
| Net change | | | -596 | -299,017,000 |

Obligation by Activity*

| Page Ref. | | 1976 Revised President's Budget Pos. | 1976 Revised President's Budget Amount | 1976 Appropriation Pos. | 1976 Appropriation Amount | 1977 Estimate Pos. | 1977 Estimate Amount | Increase or Decrease Pos. | Increase or Decrease Amount |
|---|---|---|---|---|---|---|---|---|---|
| | Community health services: | | | | | | | | |
| 21 | a) Community health centers | --- | 155,190,000 | --- | 196,648,000 | --- | 155,190,000 | --- | -41,458,000 |
| 25 | b) Comprehensive health grants to States | --- | 67,500,000 | 63 | 90,000,000 | --- | --- | -63 | -90,000,000 |
| 27 | c) Maternal and Child Health: | | | | | | | | |
| | 1) Grants to States | 58 | 205,522,000 | 58 | 295,700,000 | 58 | 193,922,000 | --- | -101,778,000 |
| | 2) SIDS | 10 | 200,000 | 10 | 2,500,000 | 10 | --- | --- | -2,500,000 |
| | 3) Research & Training | --- | 18,600,000 | --- | 23,708,000 | --- | 17,500,000 | --- | -6,208,000 |
| | Subtotal | 68 | 224,322,000 | 68 | 321,908,000 | 68 | 211,422,000 | --- | -110,486,000 |
| 31 | d) Family planning | --- | 79,435,000 | --- | 100,615,000 | --- | 79,435,000 | --- | -21,180,000 |
| 33 | e) Migrant Health | --- | 19,200,000 | --- | 25,000,000 | --- | 19,200,000 | --- | -5,800,000 |
| 36 | f) Health maintenance organizations: | | | | | | | | |
| | 1) Grants and contracts | --- | 15,727,000 (15,000,000) | --- | 15,727,000 (15,000,000) | --- | 15,000,000 (15,000,000) | --- | -727,000 (---) |
| | 2) Program support | 129 | 3,612,000 | 129 | 3,612,000 | 129 | 3,612,000 | --- | --- |
| | Subtotal, Obligations | 129 | 19,339,000 (18,612,000) | 129 | 19,339,000 (18,612,000) | 129 | 18,612,000 (18,612,000) | --- | -727,000 (---) |
| 38 | g) National health service corps | 551 | 17,529,000 (12,529,000) | 701 | 20,000,000 (15,000,000) | 676 | 24,529,000 (24,529,000) | -25 | +4,529,000 (+9,529,000) |
| 41 | h) Hypertension | --- | --- | --- | 3,750,000 | --- | --- | --- | -3,750,000 |
| 42 | i) Home Health services | --- | --- | --- | 3,000,000 | --- | --- | --- | -3,000,000 |
| 43 | j) Hemophilia | --- | --- | --- | 3,000,000 | --- | --- | --- | -3,000,000 |
| | Subtotal, Obligations | 748 | 582,515,000 (576,788,000) | 961 | 783,260,000 (777,533,000) | 873 | 508,388,000 (508,388,000) | -88 | -274,872,000 (-269,145,000) |
| | Quality Assurance: | | | | | | | | |
| 45 | a) Medical care standards | 170 | 4,187,000 | 170 | 5,187,000 | 170 | 4,187,000 | --- | -1,000,000 |

Obligation by Activity*

| Page Ref. | | 1976 Revised President's Budget Pos. | Amount | 1976 Appropriation Pos. | Amount | 1977 Estimate Pos. | Amount | Increase or Decrease Pos. | Amount |
|---|---|---|---|---|---|---|---|---|---|
| 47 | b) Professional standards review organ... | 173 | 47,582,000<br>(26,448,000) | 173 | 47,582,000<br>(26,448,000) | 221 | 62,000,000<br>(27,066,000) | +48 | 14,418,000<br>(+618,000) |
| | Subtotal, Obligations .. | 343 | 51,769,000<br>(26,448,000) | 343 | 52,769,000<br>(26,448,000) | 391 | 66,187,000<br>(27,066,000) | +48 | +13,448,000<br>(+618,000) |
| | Patient care and special health services: | 4,801 | | 5,479 | | 4,913 | | -566 | |
| 50 | a) Patient care .. | | 120,333,000<br>(105,164,000) | | 136,056,000<br>(116,164,000) | | 125,056,000<br>(105,164,000) | | -11,000,000<br>(-11,000,000) |
| 52 | c) Federal employee health | 267 | 6,830,000<br>(606,000) | 267 | 6,830,000<br>(606,000) | 267 | 7,007,000<br>(606,000) | | +177,000<br>(---) |
| 54 | d) Payment to Hawaii ..... | | ---<br>1,200,000 | | ---<br>1,200,000 | | ---<br>1,200,000 | | ---<br>--- |
| | Subtotal, Obligations .. | 5,068 | 128,363,000<br>(106,970,000) | 5,746 | 144,086,000<br>(117,970,000) | 5,180 | 133,263,000<br>(106,970,000) | -566 | -10,823,000<br>(-11,000,000) |
| 55 | Emergency medical services ..... | | ---<br>25,100,000 | | ---<br>37,025,000 | | ---<br>25,100,000 | | ---<br>-11,925,000 |
| 58 | Buildings and facilities ..... | | ---<br>13,815,000<br>(---) | | ---<br>13,815,000<br>(---) | | ---<br>---<br>(---) | | ---<br>-13,815,000<br>(---) |
| | | 941 | | 941 | | 951 | | +10 | |
| 59 | Program management | | 29,663,000 | | 30,663,000 | | 29,663,000 | | -1,000,000 |
| | Total Obligations .. | 7,100 | 831,225,000<br>(764,969,000) | 7,991 | 1,061,618,000<br>(989,639,000) | 7,395 | 762,601,000<br>(697,187,000) | -596 | -299,017,000<br>(-292,452,000) |

* Where budget authority differs from obligations, budget authority is shown in parentheses.

Obligations by Object

| | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Total number of permanent positions | 7,991 | 7,395 | -596 |
| Full-time equivalent of all other positions | 450 | 441 | -9 |
| Average number of all employees | 7,712 | 7,482 | -230 |
| Personnel compensation: | | | |
| Permanent positions | $105,421,000 | $104,215,000 | $-1,206,000 |
| Positions other than permanent | 4,985,000 | 5,187,000 | +202,000 |
| Other personnel compensation | 6,957,000 | 7,159,000 | +202,000 |
| Special personal services payments | 375,000 | 375,000 | --- |
| Subtotal, personnel compensation | 117,738,000 | 116,936,000 | -802,000 |
| Personnel benefits | 22,788,000 | 22,816,000 | +28,000 |
| Benefits for former personnel | --- | --- | --- |
| Travel and transportation of persons | 4,575,000 | 4,370,000 | -205,000 |
| Transportion of things | 1,998,000 | 1,717,000 | -281,000 |
| Rent, communications and utilities | 9,741,000 | 8,085,000 | -1,656,000 |
| Printing and reproduction | 916,000 | 868,000 | -48,000 |
| Other services | 33,519,000 | 23,460,000 | -10,059,000 |
| Project contracts | 50,442,000 | 63,323,000 | +12,881,000 |
| Supplies and materials | 17,260,000 | 14,615,000 | -2,645,000 |
| Equipment | 5,303,000 | 4,731,000 | -572,000 |
| Lands and structures | 7,022,000 | --- | -7,022,000 |

Obligations by Object

| | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Investments and loans..... | --- | --- | --- |
| Grants, subsidies and contributions..... | 790,516,000 | 501,880,000 | -288,636,000 |
| Subtotal..... | 1,061,818,000 | 762,801,000 | -299,017,000 |
| Deduct quarters and subsistance charges (-). | -200,000 | -200,000 | --- |
| Total obligations by object..... | 1,061,618,000 | 762,601,000 | -299,017,000 |

Significant Items in House and Senate Appropriations Committee Reports

| Item | Action Taken or to be Taken |
|---|---|
| **1976 House Report** | |
| **Community Health Services** | |
| 1. The Committee expects a report from the Health Services Administration prior to the hearings on the 1977 budget on the steps it has taken to improve the management of its programs as well as the steps taken to improve reimbursements from third party sources, with special emphasis on the maternal and child health program. | A report will be furnished to the Committee prior to the fiscal year 1977 budget hearings. |
| **Patient Care and Special Health Services** | |
| 2. The Committee directive that there be no reduction in the 1975 position level and that the employment ceiling be raised to permit the hospitals to render services at a level and range comparable to the January 1, 1973 level in accordance with the provisions of Public Law 93-155 (page 16). | The operating ceiling for 1976 was set at 5,479, the same as the number of positions in 1975 and the 1976 Continuing Resolution. Distribution of the full ceiling was made November 28, 1975. |
| **1976 Senate Report** | |
| **Maternal and Child Health** | |
| 1. The Committee noted that the 160 MCH staff positions assigned to the maternal and child health program be filled and that both regional and central office personnel be maintained as identifiable units, devoting 100 percent of their time to maternal and child health service activities. | No action has been taken to carry out the Senate directive. Such action would require a reorganization of BCHS Central Office and each of the 10 HEW Regional Offices, since they are organized on a 'functional' basis rather than a 'categorical' basis. To provide clarity to the request, the 1977 budget specifically identifies the activity of these 160 MCH positions, although they are located and funded in 2 budget activities -- MCH grants to States (68, of which 58 are MCH and 10 SIDS), and program management (102 for MCH). |

Significant Items in House and Senate Appropriations Committee Reports

| Item | Action Taken or to be Taken |
|---|---|
| **1976 Senate Report** | |
| **Patient care and special health services** | |
| 2. The Committee directive for the Secretary to submit within six months following enactment of the bill a report certifying that the Department is in compliance with Section 818 of Public Law 93-155 or setting out the specific steps which must be taken before he can give such certification (page 29). | The Health Services Administration will develop this report for the Secretary to submit to Congress to arrive within six months following enactment. |
| **Program Management** | |
| 3. The Committee noted its concern that staffing (positions and cost) for many Health Services Administration categorical programs were hard to determine. | The fiscal year 1977 budget includes separate identification for categorical programs in the program management narrative justification. It specifically identifies the estimates for all categorical programs not otherwise identified in other budget activity estimates. |
| **1976 Conference Report** | |
| **Patient care and special health services** | |
| 1. The conferees direct the Secretary to submit to Congress a report either certifying that the Department is in compliance with Section 818 of P.L. 93-155 or setting out specific steps before he can give such certification. | The Health Services Administration will develop this report for the Secretary to submit to Congress. |

Authorizing Legislation

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| Community health services: | | |
| a) Community health centers | $240,000,000 | $155,190,000 |
| b) Comprehensive health grants to states | 125,000,000 1/ | -- |
| c) Maternal and child health: | 350,000,000 2/ | |
| 1) Grants to states | | 193,922,000 |
| 2) SIDS | 3,000,000 | -- |
| 3) Research and training | | 17,500,000 |
| d) Family planning | 182,500,000 | 79,435,000 |
| e) Migrant health | 44,000,000 | 19,200,000 |
| f) Health maintenance organizations | | |
| 1) Grants and contracts | 85,000,000 | 15,000,000 |
| 2) Program support | Indefinite | 3,612,000 |
| g) National health service corps | 3/ | 24,529,000 |
| h) Home health services | 4/ | -- |
| i) Hemophilia | | |
| 1) Treatment centers | 4,000,000 | -- |
| 2) Blood separation centers | 5,000,000 | -- |
| Quality assurance: | | |
| 1) Medical care standards | Indefinite | 4,187,000 |
| 2) Professional standards review organizations | Indefinite | 87,082,000 |
| Patient care and special health services: | | |
| 1) Patient care | Indefinite | 105,164,000 |
| 2) Coast guard medical services | Indefinite | -- |
| 3) Federal employee health | Indefinite | 606,000 |
| 4) Payment to Hawaii | Indefinite | 1,200,000 |
| Emergency medical services | 3/ | 25,100,000 |
| Building and facilities | Indefinite | -- |
| Program management | Indefinite | 29,663,000 |

1/ This authorization includes $15,000,000 for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.
2/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.
3/ Authorization expires June 30, 1976. Extension legislation is proposed.
4/ This program was authorized for 1976 only at a level of $10,000,000.

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Health Services

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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 fund 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 | 689,915,000 | 735,155,000 | 828,657,000 | 735,155,000 |
| Trust fund transfers | 7,237,000 | 7,237,000 | 7,237,000 | 7,237,000 |
| 1974 | 812,456,000 | 812,456,000 | 855,806,000 | 918,624,000 |
| Trust fund transfers | 20,551,000 | 20,551,000 | 20,551,000 | 20,551,000 |
| 1975 | 911,683,000 | 919,562,000 | 946,157,000 | 946,157,000 |
| Trust fund transfers | 32,694,000 | 32,694,000 | 32,694,000 | 32,694,000 |
| 1976 | 418,315,000 | 545,218,000 | 551,835,000 | 549,226,000 |
| Supplemental | 266,354,000 | 432,013,000 | 440,013,000 | 437,013,000 |
| Trust fund transfers | 26,321,000 | 26,321,000 | 26,321,000 | 26,321,000 |
| 1977 | 697,187,000 | | | |
| Trust fund transfers | 39,121,000 | | | |

18

HEALTH SERVICES ADMINISTRATION

Justification

Health Services

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 1977 the Health Services Administration will continue to emphasize these goals through efforts to improve project management, including a focus on the quality of care provided, and efforts to maintain third-party reimbursements in its project grant programs.

The programs administered by the Bureau of Community Health Services have fundamental interests in the maintenance and extension of health service capacity in order to resolve problems of access to health care. they provide a mechanism for meeting the special health needs of people who have difficulty in gaining access to care.

The Bureau of Community Health Services staff will place continued emphasis on improving project management and maintaining third-party reimbursements. The program indicators and reporting requirements will continue to be emphasized as they have produced, and will continue to produce, improved project management and decreases in the annualized costs per persons served. This is necessary in order to maintain existing health care services to the extent possible. This effort is particularly significant for the people currently being served in Community health centers, family planning projects, and migrant health projects.

The national concerns about the quality of health care have resulted in the implementation of the Professional Standards Review Organization (PSRO) program, the End Stage Renal Disease program, and other quality assurance activities within the Health Services Administration. PSRO's provide a mechanism for professional control over the inappropriate utilization of health services and for 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 seaman, Public Health Service Commissioned Corps, the other statutory recipients. However, due to a long term decrease in patient load and to other factors, legislation will be submitted to permit the transfer to community use or the closure of the eight Public Health Service general hospitals.

In response to the fact that health care needs vary from State to State, and to the fact that State and local officials rather than Federal officials are in the best position to discern those needs, several formula and project grant programs within the Health Services Administration are proposed to be merged with other health planning and health services programs in other agencies into a single health block grant in 1977. The affected Health Services Administration programs are Community Health Services, Maternal and Child Health Services, Family Planning, Migrant Health, Emergency Medical Services, and the special payment to the State of Hawaii for the care of persons with Hansen's disease. The funding levels requested for these programs in this budget are designed to provide continuity while the necessary changes in legislation are being sought.

Community Health Services

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Community Health Centers .. | --- | $155,190,000 | --- | $196,648,000 | --- | $155,190,000 | --- | -$41,458,000 |
| Comprehensive Health Grants to States .... | --- | 67,500,000 | 63 | 90,000,000 | --- | --- | -63 | -90,000,000 |
| Maternal and Child Health | 68 | 224,322,000 | 68 | 321,908,000 | 68 | 211,422,000 | --- | -110,486,000 |
| Family Planning ..... | --- | 79,435,000 | --- | 100,615,000 | --- | 79,435,000 | --- | -21,180,000 |
| Migrant Health .... | --- | 19,200,000 | --- | 25,000,000 | --- | 19,200,000 | --- | -5,800,000 |
| Health Maintenance Organizations ... | 129 | 19,339,000 | 129 | 19,339,000 | 129 | 18,612,000 | --- | -727,000 |
| Budget Authority ..... | --- | (18,612,000) | --- | (18,612,000) | --- | (18,612,000) | --- | (---) |
| National Health Service Corps ..... | 551 | 17,529,000 | 701 | 20,000,000 | 676 | 24,529,000 | -25 | +4,529,000 |
| Budget Authority ..... | --- | (12,529,000) | --- | (15,000,000 | --- | (24,529,000) | --- | (+9,529,000) |
| Hypertension | --- | --- | --- | 3,750,000 | --- | --- | --- | -3,750,000 |
| Home Health Services .. | --- | --- | --- | 3,000,000 | --- | --- | --- | -3,000,000 |
| Hemophilia . | --- | --- | --- | 3,000,000 | --- | --- | --- | -3,000,000 |
| Total .... | 748 | 582,515,000 | 961 | 783,260,000 | 873 | 508,388,000 | -88 | -274,872,000 |
| | | (576,788,000) | --- | (777,533,000) | --- | (508,388,000 | --- | (-269,872,000) |

20

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. It is recognized, however, that these health services needs vary among populations in different sections of the country. State and local governments are better able to determine the priority needs of their constituencies than is the Federal government. For this reason, a number of Community Health Services programs are proposed to be consolidated into a block grant to States beginning in fiscal year 1977. The Community Health Services programs foster a comprehensive approach to health care services with special emphasis on reaching underserved segments of the population. As part of the Health Services Administration, the Bureau's activities are coordinated with programs serving statutorily defined populations, the Indian Health Service and the Federal Health Programs Service. Its efforts in maintaining service effectiveness are related to the programs of the Bureau of Quality Assurance. Most importantly, Bureau of Community Health Services' authorities are being coordinated among themselves and with other Public Health Service resources in the Health Resources Administration, Alcohol, Drug Abuse, and Mental Health Administration in order to direct concerted service efforts to the needs of neglected populations. At this time the needs of rural America are receiving priority attention through the Public Health Rural Health Initiative.

Community health center project grants help low-income persons through the provision of health care in neighborhood and family health centers. The comprehensive health grants to States assist States in establishing and maintaining adequate public health services in accordance with their priorities and goals. 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 national health service corps provides direct health care through the placement of health personnel in areas where health manpower is scarce or non-existent.

The health maintenance organization program provides a mechanism for dealing with specific major problems in health care such as rapid inflation in medical costs, the inadequate emphasis on illness prevention and the increasing uneveness in the distribution and quality of medical care.

21

Community Health Centers

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants.. | --- | $155,190,000 | --- | $196,648,000 | --- | $155,190,000 | --- | -$41,458,000 |

The major focus of the Community Health Center's program continues to be the development of health services delivery capacity in medically underserved areas of this Nation and the continued support of ambulatory health care projects located in rural and urban medically underserved areas. Funds are used for health service capacity building through a "front-end" financing approach (i.e. start-up costs for new health delivery organizations). It is intended that they help support the development of integrated systems of care and that they serve as a catalyst for the development of new and innovative approaches.

Community Health Centers' project grants are awarded to public and private entities to assist them in meeting costs associated with the planning and development and for the continuing operation of community health centers. These projects integrate a broad range of health and social services into a single organization and assure accessible ambulatory care and incorporate sound preventive health measures. These services are provided principally to a medically underserved population of an urban or rural area designated as an area with a shortage of personal health services or a population group designated as having a shortage of such services. They are predicated on total family care and are designed to insure continuity of high quality health care.

In 1977, efforts to improve management efficiency, program effectiveness and the quality of care will continue so as to maintain high quality health care for those who live in medically underserved areas.

The 157 operational Community Health Centers and 77 rural health initiative projects provided a range of preventive, curative, and rehabilitative ambulatory services and arranged for inpatient services to an estimated 1,872,000 persons in 1976, an increase of 447,000 persons (31%) over 1975. Significant program activity has been devoted to working with health 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 20 percent of total operating costs in 1975 to 22 percent in 1976.

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. Explicit program expectations were implemented for all centers using already defined program reporting requirements. These program indicators and funding criteria permitted continued improvement for project funding decisions in 1976. Improvements in project management by judicious application of the Program Indicators and Funding Criteria resulted in an overall decrease of 23 percent in the annualized total cost per person served by the centers (from $204 in 1975 to $157 in 1976). Data reported in the 1974 Statistical Abstract of the United States for the total population

indicate that the National per capita cost is $214 for services which are most comparable to those delivered in Community Health Centers.

Impact of 1977 Budget: The 1977 budget level will provide support to 137 projects serving 1,308,000 persons. This represents a reduction of 20 Community Health Centers and 77 rural health initiative projects and 564,000 people served in 1976. Funds in this request will be included in the proposed block grant for health. This block grant program would permit States and local governments to allot funds to the highest priority health service needs, as determined by them.

The following table illustrates the impact of the 1977 Budget:

| | 1975 Actual | 1976 Conference Action | 1977 Estimate |
|---|---|---|---|
| I. Budget Data | | | |
| Budget Authority.. | $196,648,000 | $196,648,000 | $155,190,000 |
| On-going CHCs..... | $187,448,000 | $190,123,000 | $155,190,000 |
| RHIs..... | $7,200,000 | $6,525,000 | --- |
| Supplemental and other Projects.. | $2,000,000 | --- | --- |
| II. Workload Data | | | |
| Total Projects.. | 204 | 234 | 137 |
| Estimated Service Population Base.. | 5,655,000 | 5,955,000 | 5,955,000 |
| Number of Persons Served ..... | 1,425,000 | 1,872,000 | 1,308,000 |
| Number of Encounters ..... | 6,555,000 | 7,881,000 | 6,016,800 |
| Cost Per Person Served all grant funds ..... | $138 | $105 | $119 |
| Cost per Encounter all grant funds.. | $30 | $25 | $26 |
| Estimated Third-Party Patient Receipts | | | |
| CHCs..... | $62,000,000 | $65,428,000 | $54,000,000 |
| Estimated Support from other sources (States, Foundations)..... | $32,000,000 | $32,000,000 | $28,000,000 |
| Total Estimated Support..... | $290,648,000 | $294,076,000 | $237,190,000 |
| Total Estimated Cost per person served..... | $204 | $157 | $181 |

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

25

Comprehensive Public Health Grants to States

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants. | --- | $67,500,000 | 63 | $90,000,000 | --- | --- | -63 | -$90,000,000 |

Comprehensive Public Health Grants to States are awarded to State health and mental health authorities on a formula basis to assist in meeting the costs of providing comprehensive public health services in accordance with priorities and goals established by the States and local governments. The program provides support for comprehensive public health services for both the general population of the States and for high risks groups, in such areas as alcoholism, cancer, chronic disease, communicable disease control, dental health, environmental health, heart disease, home health, and mental health. Data indicates that approximately four percent of all State health department budgets are supported by 314(d) funds.

Impact of 1977 Budget: No funds for this program are requested in Fiscal Year 1977. Instead, a block grant totalling $10 billion will be awarded to States to fund, at the discretion of the States, activities such as those which previously were supported under the Comprehensive Public Health Grants to States program. The following table illustrates the impact of the 1977 Budget:

| | | 1975 Actual | | 1976 Conference Action | | 1977 Estimate | |
|---|---|---|---|---|---|---|---|
| I. | Budget Data: | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| | Budget Authority: | 63 | $90,000,000 | 63 | $90,000,000 | --- | --- |
| II. | Workload Data | | | | | | |
| | Program areas supported with 314(d) funds: | | | | | | |
| | Personal health.. | 50% | | 50% | | --- | |
| | General health care and preventive services..... | 28% | | 28% | | --- | |
| | Communicable disease..... | 13% | | 13% | | --- | |
| | Chronic disease.. | 6% | | 6% | | --- | |
| | Maternal and child Health..... | 1% | | 1% | | --- | |
| | Other..... | 2% | | 2% | | --- | |

| | 1975 Actual | | 1976 Conference Action | | 1977 Estimate | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Environmental Health..... | 14% | | 14% | | --- | |
| General environmental.... | 6% | | 6% | | --- | |
| Consumer protection..... | 2% | | 2% | | --- | |
| General sanitation..... | 1% | | 1% | | --- | |
| Radiation control..... | 1% | | 1% | | --- | |
| Other..... | 4% | | 4% | | --- | |
| Health resources..... | 1% | | 1% | | --- | |
| Other programs and administration ..... | 11% | | 11% | | --- | |
| Funds to Local health departments not allocable to program areas . | 9% | | 9% | | --- | |
| Mental health activities ..... | 15% | | 15% | | --- | |

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Maternal and Child Health

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Subactivities: | | | | | | | | |
| (1) Grants to States (Section 503, 504, and 516)..... | 58 | $205,522,000 | 58 | $295,700,000 | 68 | $193,922,000 | +10 | -$101,778,000 |
| (2) Sudden Infant Death Syndrome (Title XI)..... | 10 | 200,000 | 10 | 2,500,000 | --- | --- | -10 | -2,500,000 |
| (3) Research (Section 512) and Training (Section 511) | --- | 18,600,000 | --- | 23,708,000 | --- | 17,500,000 | --- | -6,208,000 |
| Total..... | 68 | 224,322,000 | 68 | 321,908,000 | 68 | 211,422,000 | --- | -110,486,000 |

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, reduce infant mortality and prevent morbidity. In addition to providing services and managing care for severely handicapped children, standards of care are developed, facilities are licensed, 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, and habilitating them to become productive members of society. These purposes and goals are achieved through a network of existing State and local health agencies funded 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.

Impact of 1977 Budget:

- The 1977 program funding will be provided as part of a block grant, giving States the option to fund those maternal and child health activities which they perceive as most needed.
- The 1977 budget request provides $193,922,000 for Grants to States and $17,500,000 for Research and Training.
- The amount requested for Grants to States represents a $101,778,000 decrease below the 1976 operating level.
- The 1977 request for Grants to States will significantly impact on the Crippled Children's program. Services will be reduced by approximately 30% below the 1976 level.

- Ten pediatric pulmonary centers currently are providing specialized training to 109 health professionals and services to 30,000 children suffering from such illnesses as asthma, chronic bronchitis and cystic fibrosis.
- The Maternal and Child Health Research and Training program currently is supporting 21 University-affiliated training centers, nurse-practitioner and midwife training programs for 551 health professionals, and 93 research activities concerned with improving the effectiveness of comprehensive health care programs for the advancement of maternal and child health and crippled children services.
- The Sudden Infant Death Syndrome program includes 24 projects, which provide counseling services to potentially 3,350 families, and collect SIDS related research data provided by pathology reports from autopsies.
- In 1976, the Maternal and Child Health program also provided project grants in certain highly specialized areas as described below. The problems impact differently among the States' populations. Accordingly, States are in a better position than the Federal government to decide the significance of these activities upon their populations. Therefore, beginning in 1977 these activities may be funded, at the option of each State, from health block grant monies.
- There are 68 positions in the 1977 budget, which support the Maternal and Child Health programs, in addition to the 102 positions in Program Management.

The following table reflects the impact of the 1977 Budget:

| | (Non-add Columns) | | |
|---|---|---|---|
| | 1975 Actual | 1976 Conference Action | 1977 Estimate |
| Grants to States: Services provided to the following numbers of people: | | | |
| Mothers receiving prenatal and post-natal care | 600,000 | 555,000 | 405,000 |
| Infants admitted for Comprehensive services | 166,000 | 153,550 | 112,000 |
| Children registered for Comprehensive services | 1,805,000 | 1,669,625 | 1,218,800 |
| Women receiving nursing services | 1,968,000 | 1,820,400 | 1,328,900 |
| Children receiving nursing services | 3,063,000 | 2,833,275 | 2,068,300 |
| Children receiving dental treatment | 984,000 | 910,200 | 664,450 |
| Children screened: | | | |
| Visual screening | 9,846,000 | 9,107,550 | 6,648,500 |
| Audiometer testing | 6,564,000 | 6,071,700 | 4,432,350 |
| Dental screening | 3,282,000 | 3,035,850 | 2,216,200 |
| Children immunized (Including boosters and revaccinations): | | | |
| Polio | 3,008,000 | 2,782,400 | 2,031,200 |
| Rubella | 3,282,000 | 3,035,850 | 2,216,200 |
| Diptheria | 3,282,000 | 3,035,850 | 2,216,200 |
| Crippled children receiving physician services | 550,000 | 508,750 | 371,390 |

Decrease in numbers served below 1975 reflects impact of an inflation rate of 7.5% per annum.

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

Family Planning

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Subactivities: | | | | | | | | |
| (1) Family planning services... | --- | $75,135,000 | --- | $94,500,000 | --- | $75,135,000 | --- | -$19,365,000 |
| (2) Training and education.. | --- | 2,300,000 | --- | 3,600,000 | --- | 2,300,000 | --- | -1,300,000 |
| (3) Services delivery improvement.--- | | 2,000,000 | --- | 2,515,000 | --- | 2,000,000 | --- | -515,000 |
| Total..... | --- | 79,435,000 | --- | 100,615,000 | --- | 79,435,000 | --- | -21,180,000 |

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 authorizes 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.

Impact of 1977 Budget: The 1977 budget level will provide support to 2,840 projects serving 1,748,000 persons. This represents a reduction of 760 sites and 450,600 people served in 1976. Funds in this request will be included in the proposed block grant for health. This block grant program would permit States and local governments to allot funds to the highest priority health service needs, as determined by them.

The following table illustrates the impact of the 1977 Budget:

| | 1975 Actual | 1976 Conference Action | 1977 Estimate |
|---|---|---|---|
| Service grants | $94,500,000 | $94,500,000 | $75,135,000 |
| Training and education | (3,600,000) | (3,600,000) | (2,300,000) |
| Training grants | 2,000,000 | 2,000,000 | 1,000,000 |
| Training contracts | 1,000,000 | 1,000,000 | 1,000,000 |
| Education and information contracts | 600,000 | 600,000 | 300,000 |
| Service delivery improvement contracts | 2,515,000 | 2,515,000 | 2,000,000 |
| Total | 100,615,000 | 100,615,000 | 79,435,000 |
| Number of Federally assisted family planning programs and/or clinics | 3,600 | 3,600 | 2,840 |
| Number of patient medical visits to Federally-assisted projects and/or clinics | 3,600,000 | 3,600,000 | 2,798,744 |
| Number of persons enrolled in Federally-assisted family planning projects and/or clinics (Title X) | 2.200,000 | 2,200,000 | 1,749,359 |
| Average cost per person served | $70.00 | $71.00 | $71.00 |
| Number of family planning workers | 46,500 | 46,500 | 45,100 |
| Number of people trained | 6,250 | 6,250 | 4,250 |
| Pap smears | 2,284,000[1/] | 2,284,000 | 1,763,000 |
| Breast examinations | 2,333,000[1/] | 2,333,000 | 1,819,183 |

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

1/ Reported by the National family planning reporting system.

Migrant Health

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants. | --- | 19,200,000 | --- | $25,000,000 | --- | $19,200,000 | --- | -$5,800,000 |

Projects supported under this activity provide primary 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 319 of the Public Health Service Act, as amended by P.L. 94-63. 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.

Impact of 1977 Budget: The 1977 budget level will provide support to 97 projects serving 353,000 persons. This represents a reduction of 8 projects and 46,000 people served in 1976. Funds in this request will be included in the proposed block grant for health. This block grant program would permit States and local governments to allot funds to the highest priority health service needs, as determined by them.

The following table illustrates the impact of the 1977 budget:

| | 1975 Actual | 1976 Conference Action | 1977 Estimate |
|---|---|---|---|
| Workload Data | | | |
| Number of programs | 105 | 112 | 97 |
| Operational: | | | |
| Projects | 105 | 105 | 97 |
| Centers | -- | -- | -- |
| Developmental: | | | |
| Centers | -- | 7 | -- |
| Potential eligible population | 3,000,000 | 3,000,000 | 3,000,000 |
| Persons served | 390,000 | 399,000 | 353,000 |
| Number of encounters | 640,000 | 655,000 | 565,000 |
| Cost per person served (from grant funds) | $61 | $61 | $54 |
| Cost per encounter | $37 | $37 | $34 |
| Developmental Centers - 7 each year | -- | $1,500,000 | -- |
| Hospitalization Program | | | |
| Total cost | $2,256,000 | $1,500,000 | -- |
| People served | 3,040 | 1,875 | -- |
| Sanitation Program | | | |
| Project staff trained | 50 | 60 | -- |
| State programs assistance contracts | $300,000 | $450,000 | -- |
| Migrant labor housing study | -- | $250,000 | -- |
| Number of projects in the referral system | 15 | 105 | 97 |
| Number of projects offering dental services | 62 | 62 | 58 |
| Number of projects with evening hours | 63 | 85 | 85 |

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

Health Maintenance Organizations

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Subactivities: | | | | | | | | |
| (1) Financial assistance grants & contracts... | --- | $15,727,000 | --- | $15,727,000 | --- | $15,000,000 | --- | -$727,000 |
| Budget Authority.. | | (15,000,000) | | (15,000,000) | | (15,000,000) | | ( --- ) |
| (2) Direct Loan & loan guarantee fund 1/ .... | --- | --- | --- | --- | --- | --- | --- | ( --- ) |
| Budget Authority.. | --- | ( --- ) | --- | ( --- ) | --- | ( --- ) | --- | ( --- ) |
| (3) Program Support..... | 129 | 3,612,000 | 129 | 3,612,000 | 129 | 3,612,000 | --- | --- |
| Budget Authority.. | --- | (3,612,000) | --- | (3,612,000) | --- | (3,612,000) | --- | ( --- ) |
| Total ..... | 129 | | 129 | | 129 | | --- | |
| Budget | | 19,339,000 2/ | | 19,339,000 2/ | | 18,612,000 | | -727,000 |
| Authority.. | | (18,612,000) | | (18,612,000) | | (18,612,000) | | (--) |

The Health Maintenance Organization Act of 1973 (P.L. 93-222) is a Program enacted to encourage the development of health maintenance organizations as an alternative to the traditional fee-for-service delivery system. Health maintenance organizations are cost effective delivery mechanisms which provide good quality health care and provide the public with a meaningful choice in the way they receive and pay for health care. 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.

1/ The loan fund is a revolving fund and is replenished as loans are sold to the Federal Financing Bank.

2/ This includes $727,000 which is rural set-aside funds carried over from 1975.

Impact of 1977 Budget: The table below illustrates the funding pattern to be implemented:

| | 1976 | | | 1977 | | |
|---|---|---|---|---|---|---|
| | No. | Average Cost | Total Cost | No. | Average Cost | Total Cost |
| Feasibility | 32 | $50,000 | $1,600,000 | --- | --- | --- |
| Planning | 21 | 125,000 | 2,627,000 | 24 | $125,000 | $3,000,000 |
| Initial Development | 15 | 767,000 | 11,500,000 | 15 | 800,000 | 12,000,000 |
| Non-metropolitan area projects | (14) | | (3,000,000) | (9) | | (3,000,000) |
| | 68 | | 15,727,000 1/ | 39 | | 15,000,000 |
| Loans for Initial Operation | 25 | 1,500,000 | (37,500,000) | 14 | 1,500,000 | (21,000,000) |
| Program Support | --- | | 3,612,000 | --- | | 3,612,000 |
| Total | 93 | | 19,339,000 1/ | 53 | | 18,612,000 |

At a grant availability of $15,000,000, selection of projects will be based on highest probability for success and will permit the new feasibility projects initiated in 1976 to be supported fully for planning (24 projects) in 1977 together with 15 development projects. The 24 planning projects will be funded at approximately $125,000 each and the 15 development projects at an average of $800,000 each.

The loan and loan guarantee fund will continue to support 27 operational projects funded in 1975 and 1976. An additional 14 operational loans will be made. The number of new loans to be placed in 1977 is based on program projections which assume that 90% of the initial development projects funded in 1976 will proceed into operations and seek and receive loan support.

For program support $3,612,000 and 129 positions are included. Program support activities include provision of technical assistance to potential health maintenance organizations and guidance in the implementation of Public Law 93-222.

Summary: The 39 planning and initial development projects to be funded plus the 14 loans for initial operations to be placed will eventually generate 50 HMOs which at maturity will have a potential of serving 1,500,000 enrollees. The Office of Health Maintenance Organization Qualification and Compliance will promote the program for qualifying HMOs seeking recognition as qualified health maintenance organizations; administer the mandatory offering of the health maintenance organization alternative in Employees Benefits Plans (dual choice) and maintain surveillance to assure continuous compliance by qualified health maintenance organizations to the requirements of the statute and regulations. 100 additional applications will be processed in 1977.

1/ Includes $727,000 in rural set-aside funds carried forward from 1975.

National Health Service Corps

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation and benefits. | 551 | $12,487,000 | 701 | $13,307,000 | 676 | $15,600,000 | -25 | +$2,293,000 |
| Other expenses | --- | 5,042,000 | --- | 6,693,000 | --- | 8,929,000 | --- | +2,236,000 |
| Total..... | 551 | 17,529,000 | 701 | 20,000,000* | 676 | 24,529,000 | -25 | +4,529,000 |
| Budget Authority. | | (12,529,000) | | (15,000,000) | | (24,529,000) | | (+9,529,000) |

The National Health Service Corps (NHSC) was established in 1971 to improve the delivery of health services to persons living in communities and areas of the United States where availability of health personnel and services is inadequate to meet health needs. To alleviate the critical health manpower shortage, the NHSC recruits and places health teams consisting of physicians, dentists, nurses, and allied health professionals in shortage areas. The NHSC seeks to improve health services in communities by providing temporary help through immediate placement of medical personnel and concurrently pursuing policies that will encourage medical professionals, once placed, to remain in the shortage areas on a non-Federal basis. But more significantly, the NHSC is very concerned with developing community capacity to plan, build, and maintain independent systems of health care, both through NHSC efforts and as a participant in the Public Health Service Rural Health Initiative.

Impact of 1977 Budget:

$24,529,000 and 676 positions will provide services to 820,500 people in 330 communities. This level requires elimination of 25 positions provided by Conference Action on the 1976 Supplemental Appropriation.

The 1977 NHSC program level will provide for improvements to be implemented within the two major program goals: community self sufficiency development and physician retention; methods of operations will also be adjusted through specific quality improvements, participation in the Rural Health Initiative, and examination of potential participation in urban areas.

Community Self Sufficiency Development - The NHSC will both refine and add to its

* The 1976 operating level includes the 1976 President's Budget level and $5,000,000 appropriated in 1975 for obligation in 1976. The Conference Action added $2,471,000 and 150 positions to the 1976 supplemental request.

efforts in assisting communities to gain the capacity to establish and independently maintain viable health practices. Pre operational and operational assistance to sites through use of management technique experts, start-up funds, and NHSC regional staff, will improve the medical record and information system, billing system, and practice and patient management systems. The structure of sites will begin to reflect a stronger emphasis on development of 2 physician and group practice rather than solo sites. Physician extenders will be used to increase physician utilization which subsequently enhances site economic viability.

New authorization permits NHSC discretionary waiver of sites' repayment of debts incurred during initial site operations. Also newly authorized is the transfer of Federal equipment to communities. Potentially, both activities could significantly enhance specific communities' conversion to independent status, such as a dental site which otherwise would have to purchase a prohibitively expensive dental operatory when approaching independence.

Physician Retention will be enhanced through improved matching by better meeting needs and desires of both communities and assignees, increasing numbers of board eligible physicians, ensuring linkages to other provider units, increasing number of 2 physician and group practice sites, and maintaining access to regional staff for support and assistance as required.

Quality Improvements - increased emphasis on comprehensive care will be reflected in increased utilization of dental services at sites; new emphasis will be placed on patients' role in preventive medicine. Quality of care assessment will be improved through implementation of organized approaches to patient and practice management systems. Continuing medical education services to assignees will be expanded by providing audiovisual capabilities to all medical sites and by establishing formal linkages with Area Health Education Centers.

Rural Health Initiative(RHI)- procedures are underway to integrate NHSC staff and resources with other programs (Community Health Centers, Family Planning, Migrant Health, Indian Health Service) to develop stronger, more effective and efficient rural health delivery systems. The RHI maximizes the self-sufficiency potential of communities and creates a professional environment very conducive to physician retention.

Urban Efforts - problems of access to medical care in urban areas will be closely examined and evaluated in terms of determining desirability and extent of Corps assistance.

The following table illustrates the impact of the 1977 budget:

| | 1975 Actual | 1976 Conference Action | 1977 Estimate |
|---|---|---|---|
| Field Strength | 551 | 701 | 676 |
| Physicians | 342 | 450 | 419 |
| Dentists | 104 | 130 | 128 |
| Physician extenders/others | 105 | 121 | 129 |
| People served | 510,000 | 852,000 | 820,500 |
| Critical Health Manpower Shortage Areas designated | 1,128 | 1,400 | 1,550 |
| Physician shortage areas | (769) | (950) | (1,050) |
| Sites approved[1] | 445 | 550 | 650 |
| Sites staffed | 193 | 340 | 330 |
| Independent medical sites | 60 | 94 | 150 |
| Board eligible physicians recruited | 45% | 65% | 70% |
| Retention rate[2] | 26% | 35% | 40% |
| Dental sites | 55 | 100 | 100 |
| Fees collected and returned to the Federal Treasury | $2,102,000 | $2,700,000 | $3,900,000 |
| Non-Federal support personnel hired at sites | 900 | 1,700 | 1,600 |
| Nurse practitioners trained and placed | 53 | 120 | 110 |
| Rural Health Initiative[3] | | | |
| RHI sites | 47 | 105 | 105 |
| NHSC personnel assigned to RHI | 146 | 315 | 315 |

Summary: The National Health Service Corps is demonstrating its capability as a cost-effective approach to achieving a permanent improvement over the existing geographic maldistribution of medical personnel. Cost projections for the next few years indicate that the average total program cost per field assignee should not exceed $37,000 per professional. Cash receipts collected from sites and returned to Treasury for services of NHSC professionals are increasing as the number of self-sustaining sites increase. In 1977, $3,900,000 from such fees should be returned to the Treasury. The program goals of community self-sufficiency and physician retention are being met as the numbers of independent sites and provider personnel remaining in communities significantly increase.

1/ Excludes independent sites.
2/ Includes medical personnel who extend on active duty as Federal employees and those who remain on non-Federal basis.
3/ Sites and personnel included in totals above.

Hypertension Programs

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants.. | --- | --- | --- | $3,750,000 | --- | --- | --- | -$3,750,000 |

Formula grants are awarded to State health authorities for support of hypertension programs on the basis of (1) one dollar per person up to the first 10,000 population and (2) a State's population and financial need weighted by the extent of the hypertension problem within the State, to assist in meeting the costs of establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

Impact of 1977 Budget: No funds are requested for grants to State health authorities for support of hypertension programs. Instead, a block grant totalling $10 billion will be awarded to States to fund, at the discretion of the States, activities such as those supported under the Comprehensive Public Health Grants to States program.

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Home Health Services

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants. | --- | --- | --- | $3,000,000 | --- | --- | --- | -$3,000,000 |

The Home Health Services program constitutes a medically desirable and often cost-saving alternative to institutionalized care in hospitals and nursing homes. Priority is given to areas which do not have home health services or which do not have adequate access to such services. Under Title VI of P.L. 94-63, project grants are authorized to meet initial costs of establishing new agencies or expanding existing services.

Impact of 1977 Budget: Authorization for this activity expires with the current fiscal year. No funds are requested for this program in fiscal year 1977.

Hemophilia

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants.. | --- | --- | --- | $3,000,000 | --- | --- | --- | -$3,000,000 |

Section 606 of Title VI of P.L. 94-63 authorizes grants and contracts for comprehensive hemophilia diagnostic and treatment centers to 1) provide services, 2) train professional and paraprofessional personnel in hemophilia diagnosis, research and treatment and 3) provide counseling for disease victims and their families.

Section 1132 of Title VI authorizes grants and contracts for projects to develop and expand within existing facilities, blood separation centers to separate, and make available for distribution, blood components to providers of blood services and manufacturers of blood fractions.

Impact of the 1977 Budget: No funds are requested for these activities in 1977. In 1976 funds were included in the first supplemental budget request but were subsequently proposed for rescission.

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Quality Assurance

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Medical Care Standards.... | 170 | $4,187,000 | 170 | $5,187,000 | 170 | $4,187,000 | --- | -$1,000,000 |
| Professional Standards Review Organizations..... | 173 | 47,582,000 | 173 | 47,582,000 | 221 | 62,000,000 | +48 | +14,418,000 |
| Total... | 343 | 51,769,000 | 343 | 52,769,000 | 391 | 66,187,000 | +48 | +13,418,000 |

## 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.

The Professional Standards Review Organizations (PSROs) Program was designed 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, including the End Stage Renal Disease program.

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Medical Care Standards

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation..... | 170 | $3,461,000 | 170 | $3,820,000 | 170 | $3,573,000 | --- | -$247,000 |
| Other expenses.. | --- | 726,000 | --- | 1,367,000 | --- | 614,000 | --- | -753,000 |
| Total..... | 170 | 4,187,000 | 170 | 5,187,000 | 170 | 4,187,000 | --- | -1,000,000 |

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.

Impact of 1977 Budget: A total of $4,187,000 and 170 positions is requested for this activity. This represents a decrease primarily for ESRD activities, of $1,000,000 from the 1976 level of operations.

Training activities for State Survey personnel will be supported utilizing existing central and regional staff resources and with priority being given to basic orientation and training for newly employed surveyors and limited specialized training for advanced surveyors, consultants and supervisors.

Support will be provided for the regional office standards and certification program in their monitoring and provision of consultation and training resources to 52 Medicare/Medicaid survey agencies.

The program will develop, review and revise Medicare/Medicaid provider standards, guidelines, survey procedures and forms for ten (10) categories of providers of health services: General Hospitals, Psychiatric Hospitals, Skilled Nursing Facilities, Intermediate Care Facilities, Home Health Agencies, Independent Laboratories, Out-patient Physical and Speech Therapy, Independent Practice/Out-patient Physical Therapy, End Stage Renal Disease, and Portable X-ray.

For the ESRD program the goals pursued by the Bureau would include providing assistance in setting standards, the development of guidelines and survey procedures associated with the treatment of kidney disease, and assuring the quality of covered services.

The following tables indicate the impact of the 1977 budget.

1. Table of Certified Medicare/Medicaid Providers and Suppliers -

| | |
|---|---|
| Hospitals | |
| JCAH Accredited | 4,861 |
| Non-JCAH Accredited | 1,905 |
| Psychiatric | 384 |
| Skilled Nursing Facilities | 7,111 |
| Intermediate Care Facilities | 8,406 |
| Home Health Agencies | 2,255 |
| Independent Laboratories | 3,089 |
| Outpatient Physical and Speech Therapy | 119 |
| End Stage Renal Disease | 725 |
| Portable X-rays | 133 |

2. Number of Provider Validation Surveys Conducted --

| 1975 | 1976 | 1977 |
|---|---|---|
| 650 | 850 | 850 |

3. Number of Proficiency Examinations Administered

| | 1975 | 1976 | 1977 |
|---|---|---|---|
| Physical Therapist | 62 | 60 | 0 |
| Licensed Practical Nurse | 1,331 | 2,000 | 0 |
| Cytotechnologist | 179 | 290 | 0 |
| Clinical Laboratory Technologist | 4,680 | 5,000 | 0 |
| Psychiatric Technician | 1,000 | 1,000 | 0 |

Summary: The Bureau would continue its ongoing activities: in the areas of health and safety standards for existing and new providers; improve laboratory services through development of uniform standards and certification procedures; implement Utilization Review (UR) regulations and a training program for State survey personnel. In addition the following activities for the ESRD program would be carried out: planning for implementation of the Medical Information System (MIS); participation in a Certification Program for facilities under the long term ESRD program; and participation in the implementation of medical review.

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Professional Standards Review Organization

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation..... | 173 | $3,450,000 | 221 | $4,015,000 | +48 | +$565,000 |
| Other expenses..... | --- | 44,132,000 | --- | 57,985,000 | --- | +13,853,000 |
| Total..... | 173 | 47,582,000 | 221 | 62,000,000 | +48 | +14,418,000 |

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. PSROs are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local physician organizations, Statewide Councils, and a National Council supported and evaluated by the Federal Government.

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 PSROs will assume responsibility for such activities.

FY 1977 Activities: PSRO activities during 1977 will allow implementation of the program in all 203 areas, thus initiating the final transition from utilization review to PSRO. Early in 1977,55 planning PSROs will be converted to conditional status for a total of 120 conditional PSROs; 83 new planning PSROs will be funded. In addition, 10 Statewide Councils will be funded and some PSROs will initiate Long-term care review. The capability of the 120 conditional PSROs to perform review of about 65-75% of the hospital admissions will be made possible through implementation of P.L. 94-182, the new financing amendment to the Social Security Act which allows non-delegated review (review performed by the PSRO) to be financed through the Trust Funds.

Program Status at End of FY 1976: By the end of 1976, 2 additional planning PSROs will have been converted to conditional status, for a total of 65 conditional PSROs. Fifty-five PSROs will remain in planning status. Six Statewide Councils will have been established. The 65 conditional PSROs will have reviewed approximately 1.9 million hospital admissions of the 11 million Medicare/Medicaid admissions.

Examples of conditional PSRO activity are as follows:

(1) The Delmarva PSRO, Eastern Maryland (converted to conditional status in July 1975) has implemented review in four out of six hospitals. As of December 1975 early statistics reveal that Medicare and Medicaid length of stay has declined substantially (.8 to 2.8 length of stay days) in three of the four hospitals over the first two months of the PSRO program in comparison with the previous two years.

(2) The Multnomah Foundation for Medical Care (MFMC) Portland, Oregon, is presently performing admission certification and continued stay review on 100% of the elective and emergency admissions covered under Titles XVIII and XIX in all 14 acute care hospitals in PSRO Area I. Recently, MFMC began review in 12 of the 17 area Skilled Nursing Facilities on a demonstration basis. Between July 1, 1975, and January 31, 1975, MFMC will have reviewed 16,500 acute admissions and 1,000 SNF admissions as well as 1,000 admissions for eight area insurance carriers. MFMC has a current membership of 1,103 which represents 63% of the eligible physicians in the PSRO area. In a study performed by Oregon Physicians Services, involving review of admissions in certain hospitals for the period, May 1973 to September 1974 it was shown that for every dollar invested for review, 5 were saved through reduced length of stay (costs of $6,630 vs. savings of $35,900). Average length of stay fell 1.8 percent per month, greatly exceeding national trends towards shorter lengths of stay.

(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, and XIX in all 91 of the acute care hospitals in the State. 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. The Foundation has a current membership of 1,719 out of an eligible population of 3,580 physicians. A preliminary analysis of review performed of Medicaid beneficiaries in Colorado during 1974 suggests a decrease in utilization of facilities by about 10%. This amounts to a savings of about 155 days per 1,000 Medicaid beneficiaries and a net savings of about $2.4 million in 1974.

(4) The Mississippi Foundation for Medical Care (MFMC) is presently performing admission certification and continued stay review on 100% of the admissions covered under Titles XVIII, XIX, and V in 56 of the 109 acute care hospitals in the State. The remaining 54 hospitals will be under review by May 1976. Since June 1, 1975, MFMC has reviewed 35,011 PSRO admissions. The current review activity is approximately 8,000 admissions per month. The Foundation has signed Memoranda of Understanding with the Title XVIII and XIX programs. A Memoranda of Understanding with the Title V program is anticipated in the near future. The Foundation has a current membership of 1,256 out of an eligible population of 3,580 physicians.

Impact of 1977 Budget: A total of $62,000,000 and 221 positions is requested for this activity. This represents an increase of $14,418,000 and 48 positions over the 1976 level. This program is funded from Social Security Trust Funds ($34,934,000) and direct appropriated funds ($27,066,000).

The 1977 budget of $62,000,000 with full implementation of the new financing amendment by the end of the year, will allow expansion of the PSRO program to cover all 203 areas. PSROs will be funded in all areas where qualified physician organizations, still interested in participating in the program, exist. Eighty-three new planning PSROs will be funded in order to

cover all 203 PSRO areas. Early in 1977 fifty-five planning PSROs will be converted to conditional status for a total of 120 conditional PSROs. These conditional PSROs will perform review of approximately 3.0 of the total 11 million Medicare/Medicaid hospital admissions and some PSROs will initiate long term care review. The 6 Statewide Councils established in 1976 will continue to be supported in 1977, and 4 new Statewide Councils will be established for a total of 10 Statewide Councils.

The 48 positions will monitor the expanded number of PSROs and will provide technical assistance in areas such as financial management, data, peer review, organization development and monitoring. General and specialty contract funds will provide necessary support to the PSROs for such activities as development of new methodologies of review in rural areas, utilization of nonphysician health care practitioners, development of review methods for long term care facilities, ambulatory care, HMOs, etc. A significant amount of contract and evaluation funds will be applied 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. For example, the effect of concurrent review on reductions in length of stay and unnecessary admissions will be assessed as well as the impact on changes in physician behavior.

Program Plans

| | 1976 | | 1977 | |
|---|---|---|---|---|
| | No. | Amount | No. | Amount |
| S & E | | $4,672,000 | | $5,520,000 |
| Planning | | | | |
| Old | 55 | 8,240,000 | --- | --- |
| New | --- | --- | 83 | 10,375,000 |
| Subtotal | 55 | 8,240,000 | 83 | 10,375,000 |
| Conditional | | | | |
| Old | 63 | 31,500,000 | 65 | 26,035,000A. |
| New | 2 | 1,100,000 | 55 | 16,200,000 |
| Subtotal | 65 | 32,600,000 | 120 | 42,235,000 |
| State Council | 6 | 300,000 | 10 | 1,000,000 |
| Contracts and Evaluation | | 1,770,000 | | 2,870,000 |
| Total | | 47,582,000 | | 62,000,000 |

A. These 120 PSROs would also receive about $27 million for review activities of hospital admissions from the new financing system. The combined total of $69 million will support review of about 3 million M/M hospital admissions.

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Patient Care

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation and benefits | 4,801 | $83,301,000 | 5,479 | $90,373,000 | 4,913 | $88,032,000 | -566 | -$2,341,000 |
| Other expenses | | 37,032,000 | | 45,683,000 | | 37,024,000 | | -8,659,000 |
| Total | 4,801 | 120,333,000 | 5,479 | 136,056,000 | 4,913 | 125,056,000 | -566 | -11,000,000 |
| Reimbursable obligation | | 15,169,000 | | 19,892,000 | | 19,892,000 | | --- |
| Direct Obligations | | 105,164,000 | | 116,164,000 | | 105,164,000 | | -11,000,000 |

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 being provided in PHS hospitals and outpatient clinics to beneficiaries of other Federal agencies, including active duty military and their dependents, and to foreign seamen and community residents.

The program currently 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 other 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 medical and dental 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 legislative mandate of Section 818 of Public Law 93-155, which provides that the PHS facilities continue to furnish all patient care services at the operating level of January 1, 1973, unless Congress approves a proposed legislative change.

The 1977 budget proposes: 1) to submit to Congress legislation to authorize the transfer to community use or the closure of the eight Public Health Service general hospitals; 2) continuation of medical care to primary beneficiaries of the PHS on a contractual basis; 3) continued operation of the National Leprosarium at Carville, Louisiana and the PHS outpatient clinics; and 4) payments to participants in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932.

Closure or transfer to community use of the eight PHS hospitals is sought for the following reasons:

- Current use of the facilities is very low, an estimated 69% of capacity for 1976;
- Only 53% of patients using the hospitals are primary beneficiaries;
- The hospitals are located in areas where adequate community facilities are available to take care of current PHS patients if the PHS hospitals were closed. This would not adversely affect the availability of adequate hospital resources to the community;
- Five of the eight PHS hospitals (Galveston, Seattle, Baltimore, Boston, and San Francisco) are in areas with an excess of hospital beds for community needs. Continued operation of PHS facilities in such areas tends to push up community hospital costs.

Impact of 1977 Budget:

The 1977 budget estimates are predicated on the transfer to community use or the closure of the eight Public Health Service general medical and surgical hospitals. Plans will have to be formulated to provide;

- Administration of a contract health care program for the beneficiaries of the Public Health Service;
- Care of beneficiaries of other Federal agencies;
- Disposition of the PHS hospitals after patients leave;
- Continuation or phasing out of community programs established under Section 328 of the PHS Act;
- For meeting commitments under current training programs within PHS facilities.

## Federal Employee Health Services

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation and benefits | 267 | $4,406,000 | 267 | $4,484,000 | --- | +$78,000 |
| Other expenses | --- | 2,424,000 | --- | 2,523,000 | --- | +99,000 |
| Total | 267 | 6,830,000 | 267 | 7,007,000 | --- | +177,000 |
| Reimbursable obligations | | 6,224,000 | | 6,401,000 | | +177,000 |
| Direct obligations | | 606,000 | | 606,000 | | --- |

This program provides consultation on the organization and establishment of employee health services to any Federal agency requesting advice; provides standards and criteria for the furnishing of such employee health services; and when requested, assists agencies in the evaluation of such services. The program also organizes, administers, and operates Federal employee health services for participating Federal agencies on a reimbursable basis.

The services authorized include emergency diagnosis and treatment of injury or illness occurring during working hours; inservice examinations determined necessary by the Department or agency head; administration of treatments and medications under certain circumstances; preventive health services, appraisal of work environment and health hazards; health education; specific disease screening examinations and immunizations; referral to private physicians, dentists, and other community health resources.

In 1976, 100 consultations to Federal agencies, executive boards, and associations were provided on the evaluation and establishment of Federal employee health activities. Occupational health services were provided to approximately 200,000 Federal employees in 106 health units.

Impact of 1977 Budget: The $606,000 in appropriated funds will provide for continuation of employee health activities at the 1976 level. The increase of $177,000 in reimbursable funds are for built-in items of expense.

| | 1975 Actual | 1976 Estimate | 1977 Estimate |
|---|---|---|---|
| Consultation | 100 | 100 | 100 |
| Population served | 190,000 | 200,000 | 200,000 |
| Health units (Reimbursable) | 106 | 106 | 106 |

Summary: Based on the positions and funds reflected in the 1977 estimate, the program will continue to be responsive to Federal agencies for requested consultation and evaluation of their occupational health programs and will continue to operate 106 health units providing services to approximately 200,000 Federal employees.

Payment to Hawaii

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants | --- | $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. Expenses above the Federal payment are borne by the State of Hawaii.

Impact of 1977 Budget:

- This activity will be included in the health block grant.

- Cost borne by the State of Hawaii will increase by $51,500 to $932,500.

The following table illustrates the impact of the 1977 Budget:

| | 1975 Actual | 1976 Estimate | 1977 Estimate |
|---|---|---|---|
| ADPL ..... | 137 | 134 | 131 |
| Patient Days ..... | 49,998 | 48,910 | 47,450 |
| Inpatient per diem cost .... | $39.53 | $41.48 | $43.82 |
| Outpatient visits ..... | 2,154 | 2,348 | 2,583 |
| Per visit cost ..... | $17.42 | $22.16 | $20.64 |
| Total program cost ..... | $2,013,746 | $2,080,938 | $2,132,452 |
| Appropriation request ..... | $1,200,000 | $1,200,000 | $1,200,000 |

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Emergency Medical Services

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants | --- | $25,100,000 | --- | $37,025,000 | --- | $25,100,000 | --- | -$11,925,000 |

The Emergency Medical Services Systems Program (Title XII) provides for support by grants and contracts to assist in the development of regional EMS systems. Federal assistance provides for (1) the conduct of feasibility studies and planning, (2) establishment and initial operations, (3) expansion and improvement, and (4) research projects for the development of EMS systems.

Impact of the EMS Program

- The program works in cooperation with other health delivery programs of DHEW and other Federal agencies to interrelate improvement of the Federal investment in such areas as transportation, communications, training and education, and disaster coordination.

- The program has had an impact on bringing into the scope of EMS activities critical patient health programs to include trauma, burns, poisoning, high risk infants, heart attacks, acute psychiatric disturbances, and alcohol and drug overdose. The EMS systems are now more aware of these critical problems, how they are diagnosed and treated, and a need to create the capability to transfer patients to special treatment centers.

- A total of 124 EMS systems will have been initiated as a direct result of the EMS program. The systems in operation are having an impact on traumatic death and sudden illness.

- Each State and Territory has now established an organization to be responsible for EMS activities. Forty-four States have developed an EMS plan. Thirty-five States have enacted some type of licensure law for ambulances. Thirty-nine States now offer and/or require basic Emergency Medical Technician training for ambulance attendants.

- Although national total data are not available in the early stages of this program, significant data are available showing lives saved by critical patient groups from several of the projects:

  - Illinois (trauma) - A 29% reduction in vehicular accidental deaths.

  - Maryland (trauma) - 750 lives saved by the Trauma Center in one year.

  - Seattle (cardiac) - 85 lives saved in six months.

  - Nassau County, N.Y. (cardiac) - Decrease in death for myocardial infarction from 5.1% to 1.0%.

- Denver (neo-natal) - Threefold increase in survival rate of prematures with respiratory disorders.

- Arkansas (poison) - 45 lives saved during a four-month period.

- New York City (drug overdose) - Threefold reduction in death rate among addicts who participate in methodone drug registry.

Impact of 1977 Budget

- The program will continue to establish and improve EMS systems throughout the Nation. (See table)

- The program emphasis will be to stress (1) the role of States and communities to configure self-sufficient EMS systems, and (2) the development of the manpower and employment profile to staff a quality EMS system.

- The 1977 budget level will provide support to 97 regional EMS systems in some phase of operation, an increase of seven systems above 1976. On a cumulative basis, funding will have been provided to support emergency medical care systems serving a population of approximately 62,000,000 persons, an increase of 2,000,000 persons above 1976. Funds in this request will be included in the proposed health block grants. This proposal is consistent with the President's view that State and local governments are in a better position to determine their needs and priorities than the Federal Government.

The following table illustrates the impact of the 1977 Budget:

| | 1975 Actual | 1976 Estimate | 1977 Estimate |
|---|---|---|---|
| Feasibility and planning: | | | |
| No. of systems funded | 89 | 75 | -- |
| Amount | $4,875,000 | $3,400,000 | -- |
| Initial operations: | | | |
| No. of systems funded | 93 | 47 | 4 |
| Amount | $19,500,000 | $18,800,000 | $1,700,000 |
| Improvement: | | | |
| No. of systems funded | 27 | 43 | 93 |
| Amount | $8,125,000 | $10,900,000 | $23,400,000 |
| Sub-total: | | | |
| Number | 209 | 165 | 97 |
| Amount | $32,500,000 | $33,100,000 | $25,100,000 |
| Research: | | | |
| No. of grants awarded | 28 | 25 | -- |
| Amount | $4,500,000 | $3,925,000 | -- |
| Total Amount | $37,000,000 | $37,025,000 | $25,100,000 |
| Number of EMS systems which have completed funding under the EMSS Act | -- | 10 | 27 |

Summary

The EMS Program has had a significant impact on the delivery of emergency medical care. It is estimated that 124 regional EMS systems, serving 62,000,000 persons, will have been established and improved with EMS funding. These funds have been used to assist 49 of the 50 States; the District of Columbia, Puerto Rico, Guam, and the Trust Territory of the Pacific Islands. Almost 50% of available funds will have been used to serve rural areas.

These regional EMS systems have served to promote and enhance area-wide planning and the delivery of health services. Instead of supporting fragmented and isolated services, they integrate and coordinate resources and services on a regional (area-wide) basis. In order to achieve these results, the boundaries of each region have been based on the following criteria:

- Medical self-sufficiency - ability to provide quality medical services for at least 95% of the population with appropriate linkages to other systems for the most critical patient groups (i.e., burns, spinal cord injury, and acute cardiac).

- Potential for financial self-sufficiency - ability to continue to operate after the system has completed its eligibility for Federal funding.

- Contiguous to other regions - providing services for the "have-nots" as well as the "haves."

- Categorization of facilities - to eliminate duplication, reduce costs, and increase specialization (i.e., critical care units for the critical patient groups).

The 1977 budget level will provide for continuity of these programs at approximately the same level as the 1976 President's budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

Buildings and Facilities

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Other | --- | $13,815,000 | --- | --- | --- | -$13,815,000 |
| Budget authority | --- | --- | --- | --- | --- | --- |

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.

The following illustrates the number of projects to be undertaken in 1976 by type of construction or improvement.

| Category of Construction | No. of Projects | Hospitals Involved |
|---|---|---|
| Fire and Safety Code Deficiencies..... | 31 | 9 |
| Urgent Facility Repairs and Renovation..... | 33 | 9 |
| Joint Commission on Hospital Accreditation Requirements..... | 13 | 5 |
| Program Improvements..... | 25 | 9 |

Impact of 1977 Budget:

- Legislation will be submitted to Congress to transfer to community use or to close the Public Health Service hospitals, excluding the National Leprosarium at Carville, Louisiana.

- As a result of the pending transfer/closure actions, no new construction funds are requested.

Program Management

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation and benefits..... | 941 | $19,552,000 | 941 | $19,552,000 | 951 | $19,827,000 | +10 | +366,000 |
| Other expenses.... | | 10,111,000 | | 11,111,000 | | 9,836,000 | | -1,366,000 |
| Total..... | | 29,663,000 | 941 | 30,663,000 | 951 | 29,663,000 | | -1,000,000 |
| Subactivities: | | | | | | | | |
| Bureau of community health services.. | 641 | 18,929,000 | 641 | 18,929,000 | 651 | 18,826,000 | +10 | -103,000 |
| Bureau of medical services..... | 123 | 3,509,000 | 123 | 3,509,000 | 123 | 3,494,000 | --- | -15,000 |
| Office of the Administrator.... | 177 | 3,970,000 | 177 | 3,970,000 | 177 | 3,963,000 | --- | -7,000 |
| Payment to GSA.... | | 3,255,000 | | 4,255,000 | | 3,380,000 | | -875,000 |
| Total..... | 941 | 29,663,000 | 941 | 30,663,000 | 951 | 29,663,000 | +10 | -1,000,000 |

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 $1,000,000. This consists of a decrease of $875,000 for payment to GSA which is directly related to savings anticipated due to the projected early F.Y. 1977 closure or transfer to community use of the PHS hospitals and clinics. The remaining decrease of $125,000 represents a minor reduction which will be offset by higher than normal lapse rate.

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Program Management

Bureau of Community Health Services

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation and benefits..... | 641 | $13,907,000 | 641 | $13,907,000 | 651 | $13,804,000 | +10 | -$103,000 |
| Other expenses.. | --- | 5,022,000 | --- | 5,022,000 | --- | 5,022,000 | --- | --- |
| Total..... | 641 | 18,929,000 | 641 | 18,929,000 | 651 | 18,826,000 | +10 | -$103,000 |
| Sub-sub-activities: | | | | | | | | |
| Community health centers..... | 296 | 8,582,000 | 296 | 8,582,000 | 296 | 8,479,000 | --- | -103,000 |
| Maternal and child health.... | 102 | 3,438,000 | 102 | 3,438,000 | 102 | 3,438,000 | --- | --- |
| Family planning. | 110 | 3,005,000 | 110 | 3,005,000 | 110 | 3,005,000 | --- | --- |
| Migrant health.. | 40 | 1,173,000 | 40 | 1,173,000 | 40 | 1,173,000 | --- | --- |
| National health service corps... | 93 | 2,731,000 | 93 | 2,731,000 | 103 | 2,731,000 | +10 | --- |
| Total..... | 641 | 18,929,000 | 641 | 18,929,000 | 651 | 18,826,000 | +10 | -103,000 |

Program management activities relating to Bureau activities will be reduced in 1977 in view of the proposed reduction in the grant programs. Although the funding level in 1977 will be slightly below the 1976 level, the net effect of the decrease will be more significant since no funds are requested for mandatory increases in 1977. This estimate supports continuation of both central and regional activities. The following activities have been of primary interest to each Bureau program in 1976. Many of these objectives are ongoing from year to year and others will be terminated in 1976 at their completion and replaced with other program initiatives.

Community health centers - Emphasis has been placed on obtaining third-party reimbursements to cover the twenty percent reductions proposed in the 1976 President's Budget; the expansion of service delivery capability through increased productivity and efficiency of operations; the improvement of the quality of services offered in Community Health Centers; improve program management structure in conformance with new legislative authority; and expand service delivery capability through the Rural Health Initiative.

Maternal and child health - The development of systems of reporting data for activities that will assist in monitoring and evaluating the programs for Maternal and child health activities: establish criteria for development, implementation, funding and monitoring of Maternal and child health and Crippled Children's Services State Plans; plan, develop and implement a service, education and informational program as specified in Part C, Sections 1121 of the Sudden Infant Death Syndrome Act incorporating evaluation criteria which assesses the impact of the program on SIDS bereaved families who have been recipients of project services; review and assess the Reserve B projects to assure that they are of regional and national significance and in accordance with Title V legislation and long range objectives of the Bureau of Community Health Services; develop research priorities based upon determined needs and develop and implement a strategy for the research program in accordance with these needs; develop training priorities based upon determined needs and develop and implement a strategy for the training program in accordance with these needs; offer technical assistance to fifty-six jurisdictions and gather information to improve financial management.

Family planning - Activities in this program are as follows: Implement interim reporting system; implement cost reporting requirements, a model Regional Billing System, a fee collection strategy, and strategies directed at financial management and third party reimbursements; conduct multi-media campaign and develop information and education strategy, educational material for target groups, and self-instructional materials; implement training improvement guidelines and plans and a new training management system; develop and fund service integration initiative and integrate family planning services into other BCHS projects, work settings and rural areas; implement medical care guidelines and quality assurance approach, distribute quality of care information, and conduct quality of care studies; develop and implement mechanisms for improving project performance and a long-range service improvement strategy; improve central and regional office management.

Migrant health - Continuation of the delivery of health services to migrant and seasonal farmworkers; implement programs to improve environmental sanitation and develop legislative recommendations for financing migrant labor housing; implement medical care quality improvement programs in full-time comprehensive projects; implement a national record retrieval and referral system; implement a national patient referral system in all projects; and conduct special studies, develop information program and modify program to conform to new legislative requirements.

National health service corps - Objectives of this program are as follows: The recruitment and placement of health manpower professionals; develop and approve new project sites in designated areas; monitor and assist operating sites toward financial and operational self-sufficiency. In 1976, 45 physicians, 14 dentists and 40 physician extenders will either develop independent practices or extend during the fiscal year. Further, 35 sites are anticipated to go independent and 100 are to achieve financial self-sufficiency; improve quality and coverage of service at all sites: carry out operational and administrative support requirements; designate additional areas and revalidate all designations aged two years or more; integrate National health service corps activities with other Bureau programs.

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Program Management

Bureau of Medical Services

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation and benefits..... | 123 | $2,138,000 | 123 | $2,637,000 | --- | +$499,000 |
| Other expenses..... | --- | 1,371,000 | --- | 857,000 | --- | -514,000 |
| Total | 123 | 3,509,000 | 123 | 3,494,000 | --- | -15,000 |
| Sub-subactivities: | | | | | | |
| Patient care and special health services..... | 94 | 2,517,000 | 94 | 2,499,000 | --- | -18,000 |
| Emergency medical services..... | 29 | 992,000 | 29 | 995,000 | --- | +3,000 |
| Total | 123 | 3,509,000 | 123 | 3,494,000 | --- | -15,000 |

Introduction

The purpose of the program management activity is to administer and provide program support to the Bureau of Medical Services operating programs.

Patient Care and Special Health Services

In fiscal year 1977, program direction and management services will continue to be provided for all of the Bureau's operating programs --- the system for providing health care services for Public Health Service beneficiaries which include the continued operation of the National Leprosarium at Carville, Louisiana, and the system of PHS outpatient clinics; consulting on and surveying occupational health programs for Federal employees, including operation of Federal employee health units on a reimbursable basis; and the program for assisting regional communities in establishing emergency medical service systems.

With the plan to propose legislation to authorize the transfer to community use or the closure of the eight PHS general hospitals, special emphasis will be placed on administering a contract care program to provide hospitals services for PHS beneficiaries after closure or transfer of the PHS hospitals. Plans will also be developed and implemented for the orderly disposition of the Federally-owned PHS hospitals, upon closure or transfer to community use.

Emergency Medical Services

The 1977 budget request for this subactivity supports a staff necessary to:

- Administer the grant program for the development of a nationwide network of viable, regional emergency medical services systems;
- Provide technical assistance to grantees, prospective grantees and others as appropriate;
- Monitor projects to evaluate progress in accordance with the prescribed regulations;
- Establish program guidelines, grant review and award cycles, workshops and symposiums to disseminate program policy and guidances;
- Maintain program management continuity for an effective and economical method to achieve self-supporting regional emergency medical services systems for the population.

Program Management
Office of the Administrator

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel Compensation and benefits | 177 | $3,507,000 | 177 | $3,507,000 | 177 | $3,477,000 | --- | -$30,000 |
| Other expenses.... | --- | 463,000 | --- | 463,000 | --- | 486,000 | --- | +$23,000 |
| Total ..... | 177 | $3,970,000 | 177 | $3,970,000 | 177 | $3,963,000 | --- | -$ 7,000 |

Impact of 1977 Budget:

The 1976 request for this subactivity supports a central staff necessary to plan, direct, and administer 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 accomplishments. 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.

Program Management
Payment to GSA

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel Compensation and benefits | --- | --- | --- | --- | --- | --- | --- | --- |
| Other expenses.... | --- | $3,255,000 | --- | $4,255,000 | --- | $3,380,000 | --- | $-875,000 |
| Total ..... | --- | $3,255,000 | --- | $4,255,000 | --- | $3,380,000 | --- | $-875,000 |

For Payment to General Services Administration

This budget proposes $3,380,000 a reduction of $875,000. The reduction is based on the savings anticipated due to the projected early F.Y. 1977 closure or transfer to community use of the PHS hospitals and clinics.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Community health centers (PHS Act Section 330)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $196,648,000 | $240,000,000 | --- | $155,190,000 |

Purpose: The development of health services delivery capacity in medically underserved areas, the provision of high quality health services in such areas, and the use of funds for health service capacity building through a "front end" financing approach are the primary foci of the Community Health Centers Program. They integrate a broad range of health and social services into a single organization and these projects assure accessible ambulatory care and incorporate sound preventive health measures. The services are provided principally to a medically underserved population of an urban or rural area designated as an area with a shortage of personal health services or a population group designated as having a shortage of such services. Community health centers are predicated on total family care and are designed to insure continuity of high quality health care.

Explanation: Under Section 330 of the Public Health Service Act, project grants are awarded to public and private entities to assist them in meeting costs associated with the planning and development and for the continuing operation of community health centers which provide primary health care and arrange for specialty and inpatient care primarily for people in medically underserved areas where health resources are scarce or non-existent.

Accomplishments in 1976: In 1976, 157 community health centers provided a range of preventive, therapeutic, and rehabilitative ambulatory services to an estimated 1,500,000 persons. In addition, 372,000 persons were served in 77 rural health projects which were designed to build health services delivery capacity in medically underserved rural areas through the development of an integrated health services delivery system to improve the accessibility, availability and efficiency of ambulatory primary care resources in medically underserved areas. Due to improved overall management capabilities, third party reimbursements increased to 22 percent of total operating costs compared to 20 percent in 1975. The continued application of the Program Indicators and Funding Criteria resulted in improved project management and funding decision in 1976.

The analysis of the project performance using the Program Indicators for one year period indicates that the 1975 level of 2.5 primary physician encounters per hour for Community Health Centers was increased to 2.7 in 1976. The percent of total ambulatory costs that are direct ambulatory health care costs was increased to 60% in 1976 from 59% in 1975, and the percent of total ambulatory costs that are for general services and allocable costs was reduced from 30% in 1975 to 25% in 1976. 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 1977: Efforts to improve management efficiency, program effectiveness, and the quality of care will continue. Approximately 1.3 million persons will be served in 137 health centers. We will increase assurance of care effectiveness by the continued application of ambulatory health 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 reimbursements for services rendered by the centers to their clients. Funds in this request will be included in the proposed block grant for health.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Comprehensive public health grants to States (PHS Act, Section 314(d))

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 63 | $90,000,000 | $110,000,000 | --- | --- |

Purpose: These formula grants are awarded to State health and mental health authorities to assist in meeting the costs of providing comprehensive 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 financial need.

Accomplishments in 1976: 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 communicable disease control programs.

Objectives for 1977: No funds will be allocated to State public health authorities to assist in meeting the costs of providing Comprehensive health services. Instead, a health block grant totalling $10 billion will be allocated to States. The 63 Federal positions will be reduced from the Federal employment or transferred to other Federal government health programs.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services. Maternal and Child health (Title V, Social Security Act as amended through 1973, Sections 503, 504, 511, 512 and 516; Title XI, PHS Act as amended, 1974).

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 68 | $321,908,000 | 1/ | 68 | $211,422,000 |

Purpose: 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, reduce infant mortality and prevent morbidity. In addition to providing services and managing care for severely handicapped children, standards of care are developed, facilities are licensed, 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, and habilitating them to become productive members of society. These purposes and goals are achieved through a network of existing State and local health agencies funded 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.

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. Section 516 provides for supplemental allocations to States for maternal and child health services to insure that no State receives less funds under the formula distribution than it did under the formula and project distribution in 1973.

Title XI, the Sudden Infant Death Syndrome program, through grant and contract arrangements, develops and disseminates informational materials to health providers and the affected public.

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000 but is indefinite by activity. Authorization for Title XI of PHS Act is $3,000,000.

Section 511, Maternal and Child Health Training, and Section 512, Maternal and Child Health Research: 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.

Accomplishments in 1976: Continued emphasis was focused on implementing the program of projects as authorized by P.L. 93-53. Efforts were directed toward improving financial management, data collection and cost-finding techniques. The 163 projects initiated in 1975 and the 197 previously supported under project grant authority continued to receive technical assistance to prepare them to become providers of services under insurance and public health care financing programs, e.g. Medicare and Medicaid.

Estimated Numbers of People Served in 1976
under Conference Action level funding
(Non-add)

| | |
|---|---|
| Mothers receiving prenatal and post-natal care | 555,000 |
| Infants admitted for comprehensive services | 153,550 |
| Children registered for comprehensive services | 1,669,625 |
| Women receiving nursing services | 1,820,400 |
| Children receiving nursing services | 2,833,275 |
| Children receiving dental treatment | 910,200 |

Estimated Numbers of People Served in 1976
under Conference Action level funding (cont'd)
(Non-add)

| | |
|---|---|
| Children screened: | |
| Visual screening | 9,107,550 |
| Audiometer testing | 6,071,700 |
| Dental screening | 3,035,850 |
| Children immunized (Including boosters and revaccinations): | |
| Polio | 2,782,400 |
| Rubella | 3,035,850 |
| Diphtheria | 3,035,850 |
| Crippled children receiving physician services | 508,750 |

Twenty-four service demonstration projects were funded in 1976. The objectives of these projects are to 1) provide counseling services for families which lose a child due to sudden infant death syndrome, 2) increase the awareness of the public in general and community service personnel in particular, and 3) develop and strengthen linkages between community agencies such as health agencies, mental health agencies and coroner or medical examiners' offices, police and fire departments. In addition, a variety of publications and audio-visual materials were produced and disseminated.

In 1976 research activities supported 93 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 1976 the cumulative number of persons trained under the University-Affiliated Mental Retardation Centers program was 2,966.

-- The cumulative number of persons trained through 1976 under the Physicians Assistants and Nurse Practitioners Programs, started in 1972, was 609.

The following summarizes the number of trainees supported in 1976 under both programs:

-- Supported training for 551 trainees:

1. University-Affiliated Mental Retardation Centers (21 Centers)

Long-term Trainees:

| | |
|---|---|
| Physicians | 54 |
| Nutritionists | 8 |
| Pedodontists | 24 |
| Medical Social Workers | 115 |
| Psychologists | 83 |

Long-term Trainees (cont'd):

| | |
|---|---|
| Speech Therapists | 70 |
| Physical Therapists | 18 |
| Others | 40 |
| Subtotal | 412 |

2. Physicians Assistants and Nurse Practitioner Programs

Long-term Trainees:

| | |
|---|---|
| Pediatric Nurse Practitioners | 85 |
| Nurse Midwives | 30 |
| Other Physicians Assistants | 24 |
| Subtotal | 139 |
| Total | 551 |

-- The pediatric pulmonary Center program trained 109 persons in 1976.

Objectives in 1977: States will continue to provide health and related services to mothers, children and crippled children. Efforts will be directed to maximizing the utilization of funds to insure that the greatest number of persons receive services within the reduced availability of resources.

-- Programs of projects will be reduced from 280 to 205.

The Sudden Infant Death Syndrome program is proposed for termination in 1977.

Sixteen university-affiliated training centers will be supported in 1977 providing training to approximately 330 health professionals. The pediatric nurse practitioner and other physician assistants programs will train approximately 100 persons. The research activity will be continued through 74 projects directed toward improving the effectiveness and quality of services for mothers, children and crippled children.

Training Activities:

1. University-Affiliated Mental Retardation Centers (16)

Long-term Trainees:

| | |
|---|---|
| Physicians | 43 |
| Nutritionists | 6 |
| Pedodontists | 24 |
| Medical Social Workers | 94 |
| Psychologists | 60 |
| Speech Therapists | 56 |
| Physical Therapists | 14 |
| Others | 33 |
| Subtotal | 330 |

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2. Physician Assistants and Nurse Practitioner Programs

Long-term Trainees:

| | |
|---|---|
| Pediatric Nurse Practitioners | 65 |
| Nurse Midwives | 24 |
| Other Physicians Assistants | 11 |
| Subtotal | 100 |
| Total | 430 |

-- The pediatric pulmonary center training program will be phased out in 1977.

-- Funds in this request will be included in the proposed block grant for health.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Family planning project grants and contracts (PHS Act, Title X)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $100,615,000 | $182,500,000 | --- | $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 1976: The program will provide family planning services to 2,200,000 patients in 1976. Efforts to improve program efficiency and productivity and to upgrade the quality of services provided will continue. Cost reporting requirements will be implemented which will assure that funding decisions are made on a uniform cost basis. Ambulatory health care surveys and medical audits will be completed in a sample of service sites. A technical assistance program will be conducted to assist projects in implementing these initiatives.

The emphasis in training will be to improve skills of staff delivering medical services. Priority will be given to increasing the number of nurse practitioners trained by 20. Information and education activities will be directed primarily to the high risk and hard-to-reach populations, and will include a model program for delivering educational services to the mentally retarded. Special studies of informed consent education and the impact on patients' choice of methods will be initiated.

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. The Region I data system which was expanded to incorporate an automated billing system to assist in collecting third party reimbursements will be tested and implemented in other areas. Projects will receive technical assistance in implementing study and demonstration findings.

Objectives for 1977: The program will continue to provide comprehensive family planning services to approximately 1,748,000 people. Emphasis will be on providing quality services in the most cost effective manner. Addressing the maldistribution of health manpower and identifying strategies to insure that service deliverers in rural areas have the skills necessary to enable them to effectively deliver services will be priorities of the training program. An assessment of family planning manpower development and utilization will be conducted, and informed consent educational materials for teenagers and a minimum patient education program will be developed. Nutrition counselling as a component of educational services will be studied. Funds in this request will be included in the proposed block grant for health.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Migrant health (PHS, Section 319, as amended)

| 1976 Appropriation | | 1977 | 1977 Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $25,000,000 | $44,000,000 | --- | $19,200,000 |

Purpose: This program provides access to health care services for migrant and seasonal farmworkers and their families.

Explanation: Under Section 319 of the Public Health Service Act as amended support is provided to establish family health clinics and to improve the health care and health conditions of agricultural migrant workers and their families.

Accomplishments in 1976:

-- Implemented the National referral system and increased the number of projects in the system from 15 to 105.
-- Developed 7 Centers.
-- Conducted a migrant labor housing study.
-- Implemented 3 program assistance contracts to improve the sanitation in the migrant's living and working environment.
-- Provided services to 399,000 migrants and encounters to 655,000 migrants.
-- Provided hospitalization services to 1,875 persons.
-- Provided project staff training to 60 persons in the sanitation program.

Objectives for 1977: The program will continue to provide health care services to 353,000 people. No Centers will become operational in 1977. States programs assistance contracts for improvement of sanitation in migrant labor camps will be discontinued. Funds in this request will be included in the proposed block grant for health.

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HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services - Health maintenance organizations (PHS Act, Section 301 and Title XIII)

| | 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|---|
| | | | | Budget Estimate | |
| | Pos. | Amount | Authorization | Pos. | Amount |
| Budget Authority | 129 | $18,612,000 | 1/ | 129 | $18,612,000 |
| Obligations..... | 129 | 19,339,000 | | 129 | 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 on health care today, such as:

-- the rapid inflation in medical care
-- the inadequate emphasis on illness prevention
-- an increasing uneveness in the distribution and quality of medical care.

HMOs provide comprehensive health services on a prepaid capitation basis in accord with the definitions contained in the HMO Act.

Explanation: Grants and contracts for feasibility studies, planning and initial development are provided to public and private non-profit entities through financial assistance from the Health Maintenance Organization (P.L. 93-222). Priority for all types of assistance will be given to HMOs which will serve medically underserved populations; 20% of the funds are set aside for rural HMOs.

The revolving loan and loan guarantee fund was capitalized with $35,000,000. Loans are sold to the Federal Financing Bank thereby replenishing this fund, hence no additional funds are requested. Loans are made from this fund to help cover operating deficits during the first three years of an HMO's operation.

Accomplishments in 1976: The 1976 grant activity included the funding of 32 feasibility studies at an average cost of $50,000 each, 21 planning projects at approximately $125,000 each and 15 initial development activities at an average cost of $767,000 each.

1/ Financial assistance grants and contracts (1309(a)), $85,000,000; direct loans (1309(b)), $75,000,000 in the aggregate for 1974 and 1975; loan guarantees (1308(d)), indefinite; program support (301), indefinite. The initial authorization limits funding of grants and contracts to initial development projects only in 1977; however, based on testimony of the Assistant Secretary for Health on November 21, 1975 in support of a one-year extension of the HMO grant activity, planning grants are also funded in 1977.

During 1976, 25 loans totalling $37,500,000 will be placed with a potential of providing services to approximately 750,000 enrollees at the maturity of the HMOs.

Objectives for 1977: There will be no feasibility starts in this period; however, 24 planning projects at a cost of approximately $3,000,000 and 15 initial development projects costing $12,000,000 plus 14 loans for initial operations at an investment of $21,000,000 will be initiated. These will provide the nucleus for approximately 50 HMOs with a potential for eventually serving 1,500,000 enrollees.

The Office of Health Maintenance Organization Qualification and Compliance will promote the program for qualifying entities seeking recognition as qualified health maintenance organizations, administer the mandatory offering of the health maintenance organization alternative in Employees Benefits Plans (dual choice), and maintain surveillance to assure continuous compliance by qualified health maintenance organizations to the requirements of the statute and regulations. This Office deals with the total universe of health maintenance organizations and it is anticipated that in addition to the 50 applications for qualifications received during 1976, 100 additional applications will be processed in 1977.

A program support level of $3,612,000 will support 129 employees who will continue to review and monitor grants; render technical assistance to emerging HMOs and continue to support and aid all entities having received grants under P.L. 93-222.

HEALTH SERVICES ADMINISTRATION
Health Services
Program Purpose and Accomplishments

Activity: Community health services -- National Health Service Corps (PHS Act, Section 329, as amended).

| | 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|---|
| | | | | Budget Estimate | |
| | Pos. | Amount | Authorization | Pos. | Amount |
| Budget Auth... | 701 | $15,000,000 | * | 676 | $24,529,000 |
| Obligations... | 701 | $20,000,000 | | 676 | $24,529,000 |

* Authorization expires at the end of Fiscal Year 1976.

Purpose: The purpose of the National Health Service Corps (NHSC) is to help alleviate the geographic maldistribution of health manpower 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; assisting communities in developing the capacity to plan, build, and maintain their own systems of health care: and concurrently pursuing policies that will encourage health professionals, once placed, to remain in shortage areas on a non-Federal basis.

Accomplishments in 1976: In 1976, there were 551 health professionals (342 physicians, 104 dentists, and 105 nurse practitioners and allied health personnel) assigned to 270 communities in 44 States and Guam and Puerto Rico. Conference Action provided for addition of 150 medical personnel serving 182,000 people in 70 communities.

During 1976, the National Health Service Corps utilized information gained through review and evaluation of site activities and developed and put into effect, or made available, procedures useful to communities and health professionals in site operations, such as patient and practice management systems and the problem-oriented medical records system.

Evaluation of location decisions by physicians resulted in improved matching procedures, increased emphasis on recruitment of board eligible physicians (from 45% - 65% in 1976), expanded continuing medical education services such as providing audio-visual capabilities to all medical sites, and increased emphasis on establishment of group rather than solo practice sites.

During 1976, the NHSC actively participated in the Rural Health Initiative (RHI), providing up to 200 personnel for about 70 RHI sites. Integration of NHSC staff with other programs will improve the overall Federal health delivery capacity and efficiency. It will also maximize the self-sufficiency potential of the local health care delivery systems and will create a professional environment very conducive to physician retention. In 1976, the number of independent sites increased from 60 to about 94, and the retention rate increased from 26% to about 35%.

Objectives for 1977: This request will support 676 health professionals in 330 communities.

Program activities will be continued and refined to monitor and assist sites in attaining financial and operational self-sufficiency and independence. About 56 new sites will be identified and developed to replace those becoming independent in 1977. Sixty additional sites will be developed to bring the level to 330 staffed sites. About 150 areas will be newly designated as critical health manpower shortage areas bringing the total to 1,550; about 100 designated areas will be newly approved as eligible for NHSC assistance, totalling 650.

The number of board eligible physicians is expected to increase from 65% in 1976 to 70% in 1977. The number of multiple provider sites will be significantly increased in 1977. The retention rate is expected to increase from 35% in 1976 to 40% in 1977.

The utilization of waiver authority and equipment transfer as mechanisms to aid communities in attaining economic independence, although authorized in 1976, will be assessed and refined in 1977.

During 1977, there will be increased emphasis on providing comprehensive health services at sites. While the number of dental sites was increased from 55 to about 100 in 1976, procedures will be developed and implemented in 1977 to integrate the dental and medical services provided to communities.

The NHSC will continue active participation in the Rural Health Initiative. Also, problems of access to medical care in urban areas will be newly examined to determine desirability, extent, and possible mechanisms for provision of assistance.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Grants to States under Section 314(d)(7)(B) PHS Act for Hypertension Program

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $3,750,000 | $15,000,000 | --- | --- |

Purpose: These formula grants are awarded to State health authorities to assist in meeting the costs of establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

Explanation: Under Section 314(d)(7)(B) of the PHS Act, grant funds will be allocated to State health authorities on the basis of (1) one dollar per person up to the first 10,000 population and (2) on a State's population and financial need weighted by the extent of the hypertension problem within the State.

Accomplishments in 1976: Funds appropriated will be made available to State health authorities for establishing and maintaining hypertension programs.

Objectives for 1977: No funds are requested for grants to State health authorities for support of hypertension programs. Instead, a block grant totalling $10 billion will be awarded to States to fund, at the discretion of the States, activities such as those supported under the Comprehensive Public Health Grants to States program.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services - Home health services (Title VI, PHS Act as amended)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $3,000,000 | 1/ | --- | --- |

Purpose: The purpose of this program is to demonstrate the establishment and initial operation of public and non-profit private agencies which will provide home health services in areas in which such services are not otherwise available.

Explanation: Title VI provides for the making of project grants to improve the delivery of home health services. The intent is to provide initial funding with a view to the projects which are funded becoming independent of federal support.

Accomplishments in 1976: Funds for support of this program were included in the 1976 supplemental budget request and were planned for use in establishing 20 new home health agencies and providing supplemental funding to an additional 20 already existing agencies. The funds requested were subsequently proposed for rescission.

Objectives in 1977: Authorization for this program expires in 1976.

1/ This program was authorized for 1976 only at a level of $10,000,000

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services - Hemophilia programs (Sections 1131 and 1132, Title VI, PHS Act as amended)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $3,000,000 | $9,000,000 1/ | --- | --- |

Purpose: Title VI of P.L. 94-63 authorizes the support of hemophilia treatment centers which will provide treatment to sufferers in their areas, develop associations with providers distant from the centers and develop training programs in hemophilia research, diagnosis and treatment. In addition, the Act authorizes support for projects to develop and expand existing capability to separate and make blood components available to blood service providers and fraction manufacturers. If fractions are found to be in short supply, grants may also be made to existing public or non-profit manufacturers to alleviate the shortage.

Explanation: Project grants and contracts are awarded to public and non-profit entities to establish comprehensive hemophilia treatment centers and to develop and expand, within existing facilities, blood separation centers.

Accomplishments in 1976: Grants and contracts were planned for award in 1976 and funds were included for this purpose in the supplemental budget request. These funds were subsequently proposed for rescission.

Objectives in 1977: No funds are requested for these activities in 1977.

1/ $4,000,000 for Hemophilia Treatment Centers
$5,000,000 for Blood Separation Centers

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Quality assurance - Medical care standards (PHS Act, Sections 301 and 311)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 170 | $5,187,000 | Indefinite | 170 | $4,187,000 |

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 it 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 1976: In 1976, 850 provider validation surveys will have been conducted, an increase of 200 over 1975. A total of 8,260 proficiency examinations will have been administered to physical therapists, licensed practical nurses, cytotechnologists, clinical laboratory technologists and psychiatric technicians, an increase of about 1,000. In addition, final ESRD regulations will have been published and policies, procedures, and guidelines for implementation will have been developed. Surveyors of ESRD facilities will have been trained to carry out certifications and provide consultation directed towards improving services. A total of 1,700 surveyor personnel will have been trained, an increase of about 200. Phase I of the ESRD Medical Information System will have been completed and the system readied for implementation of Phase II. Planning for the establishment of Medical Review Boards will have been initiated.

Objectives for 1977: The estimate would allow for about 850 provider validation surveys, the same as 1976. Surveyor training activities for about 450 State survey personnel would be supported. Implementation of Phase II of the ESRD Medical Information System (system implementation) will be curtailed. Planning for the establishment of Medical Review Boards will continue. Health and safety standards for existing and new providers will continue to be updated and new standards that emphasize patient outcomes will be developed.

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)

| | 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|---|
| | | | | Budget Estimate | |
| | Pos. | Amount | Authorization | Pos. | Amount |
| Budget Authority.. | --- | $26,455,000 | Indefinite | --- | $27,066,000 |
| Obligations..... | 173 | 47,582,000 | --- | 221 | 62,000,000 |

Purpose: To assure, through the application of suitable procedures 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 of proper quality for which payment may be made.

Explanation: The PSRO program was authorized by the 1972 amendments to the Social Security Act. This 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 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, Statewide Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

Accomplishments in 1976: In 1976, two planning PSROs will have been converted to conditional status for a total of 65 conditional PSROs. Fifty-five PSROs will remain in planning status, and six Statewide Councils will have been established. The 65 conditionals will have performed review of about 1.9 million Medicare/ Medicaid hospital admissions.

Objectives for 1977: Early in 1977 the PSRO program will convert 55 planning PSROs to conditional status for a total of 120 conditional PSROs. The capability of these conditionals to conduct review of about 65-75% of the hospital admissions will be made possible through implementation of the new financing amendments. Eighty-three new planning PSROs will be funded. PSROs will be established in all 203 PSRO areas. Review will be performed on approximately 3.0 million Medicare/ Medicaid hospital admissions. In addition a total of 10 Statewide Councils will be established.

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)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| Budget Authority | | | | |
| 5,479 | $116,164,000 | Indefinite | 4,913 | $105,164,000 |
| Obligations | | | | |
| 5,479 | 136,056,000 | | 4,913 | 125,056,000 |

Purpose: The primary purpose of this program is to provide for the comprehensive health care of American seamen, Coast Guard, National Oceanographic and Atmospheric Administration, 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 beneficiaries of other Federal agencies, foreign seamen, 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, foreign seamen, and community programs.

Accomplishments in 1976: Health care was made available to an estimated 500,000 PHS beneficiaries, in addition to beneficiaries of other Federal agencies, foreign seamen, and community programs. There was a daily average of 1,638 inpatients and 6,236 outpatient visits to PHS facilities. Contract care in other Federal and non-Federal facilities averaged 83 inpatients per day; in addition, there will have been 76,000 outpatient visits to private physicians and dentists.

Objectives for 1977: Legislation will be submitted to Congress to authorize closure or transfer to community use of the eight Public Health Service general hospitals. The Public Health Service will continue to operate the National Leprosarium at Carville, Louisiana, and the PHS outpatient clinics. With the closure of the PHS hospitals, medical care will continue to be provided to primary beneficiaries on a contract basis. Plans will be formulated for the administration of a contract medical care program for beneficiaries and for the disposition of the Federally-owned PHS hospitals.

Closure or transfer to community use of the eight PHS hospitals is sought for the following reasons:

- Current use of the facilities is very low--an estimated 69% of capacity for 1976.

- Only 53% of the patients using the hospitals are primary beneficiaries.

- The hospitals are located in areas where adequate community facilities are available to take care of current PHS patients if the PHS hospitals were closed. This would not adversely affect the availability of adequate hospital resources to the community.

- Five of the eight PHS hospitals (Galveston, Seattle, Baltimore, Boston, and San Francisco) are in areas with an excess of hospital beds for community needs. Continued operation of the PHS facilities in such areas tends to push up community hospital costs.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Federal employee health services (P.L. 79-658, August 8, 1946 (5 USC 7901)

| 1976 Appropriation | | 1977 | 1977 Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | Authorization | Pos. | Amount |
| **Budget Authority** | | | | |
| 267 | $606,000 | Indefinite | 267 | $606,000 |
| **Obligations** | | | | |
| 267 | 6,830,000 | | 267 | 7,007,000 |

Purpose: Appropriated funds are used to provide consultation services and to make surveys of existing health services, when requested by Federal agencies, on the conduct of Federal employee occupational health programs. This program also operates health units providing occupational health services to Federal agencies on a reimbursable basis.

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 for consultation services to 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, and upon request, employee health services to Federal agencies.

Accomplishments in 1976: In 1976, 100 consultations to Federal agencies, executive boards, and associations were provided on the evaluation and establishment of Federal employee health activities. Occupational health services were provided to approximately 200,000 Federal employees in 106 health units.

Objectives for 1977: The estimate for 1977 provides for continuation of employee health activities at the 1976 level. The program will continue to be responsive to Federal agencies for requested consultation and evaluation of their occupational health programs and will continue to operate 106 health units providing services to approximately 200,000 Federal employees.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Payment to Hawaii (PHS Act, Section 331)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | 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 1976: Care will be provided to an estimated daily average of 134 inpatients. This is a continuation of the decreasing inpatient load of recent years. Of the total program costs estimated to be $2,081,000, the share borne by Hawaii is $881,000.

Objectives for 1977: The average daily patient load is expected to be 131 in 1977. The total program requirements are estimated to be $2,132,500 of which the Federal Government will pay $1,200,000. Funds in this request will be included in the proposed block grant for health.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Emergency Medical Services (PHS Act, Title XII)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $37,025,000 | 1/ | --- | $25,100,000 |

Purpose: The Emergency Medical Services Systems program was established in 1973 to support the implementation of self-supporting regional emergency medical services systems, which have direct impact on the loss of life due to accidental injury and sudden illness. These EMS systems should be accessible to virtually all of the Nation's citizens.

Explanation: 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 1976: During 1976, an estimated 75 planning studies will be undertaken, 47 regional systems will have had financing completed toward establishing and operating basic life support emergency medical services systems, and 43 regions will be in the process of expanding and improving existing advanced life support emergency medical services systems.

Objectives for 1977: The budget estimate will provide financing for four regions to initiate a program for the establishment and initial operation of an EMS system, and 93 regions will have received financing to expand and improve their existing advanced life support systems. On a cumulative basis, 124 self-supporting regional emergency medical services systems will be in some phase of operational development, serving a population of approximately 62,000,000. The following table indicates the estimated number of emergency medical services systems and available financing for the various sections of the Emergency Medical Services Systems Act. Funds in this request will be included in the proposed block grant for health.

1/ Legislative authority for the program expires June 30, 1976. New legislation has been proposed.

| | 1976 | 1977 |
|---|---|---|
| Feasibility and planning: | | |
| No. of systems funded | 75 | -- |
| Amount of available financing | $3,400,000 | -- |
| Initial operations: | | |
| No. of systems funded | 47 | 4 |
| Amount of available financing | $18,800,000 | $1,700,000 |
| Expansion and improvement: | | |
| No. of systems funded | 43 | 93 |
| Amount of available financing | $10,900,000 | $23,400,000 |
| Sub-total: | | |
| No. of systems funded | 165 | 97 |
| Amount of available financing | $33,100,000 | $25,100,000 |
| Research: | | |
| No. of grants awarded | 25 | -- |
| Amount of available financing | $3,925,000 | -- |
| Total amounts of available financing | $37,025,000 | $25,100,000 |

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HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Buildings and facilities

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| Budget Authority | | | | |
| --- | --- | Indefinite | --- | --- |
| Obligations | | | | |
| --- | $13,815,000 | | --- | --- |

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 1976: Obligations are directed toward upgrading the PHS hospitals. In 1976, approximately $14 million from prior year balances will be obligated to support repair and improvement projects, i.e., 31 projects for fire and safety code deficiencies, 33 projects for urgent facility repairs and renovation, 13 projects to meet the Joint Commission on Hospital Accreditation requirements, and 25 projects for program improvements.

Objectives for 1977: The budget policy is to propose new legislation to transfer to community use or to close the Public Health Service hospitals, excluding outpatient clinics and the National Leprosarium at Carville, Louisiana. Under this policy, budget authority for construction activities is not requested in 1977.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Program management--Bureau of community health services (PHS Act, Section 301)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 641 | $18,929,000 | Indefinite | 651 | $18,826,000 |

Purpose: This activity provides for the overall planning, direction, and administration for the programs of the Bureau of Community Health Services (BCHS).

Explanation: This is a direct operating program which includes salaries and other operating funds to provide management support for the Bureau of Community Health Services. 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 provide 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 1976: In 1976, efforts were directed toward 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.

Maternal and child health program objectives for 1976 were met, including the development of cost and utilization reporting requirements, implementation of a program for assisting States in analyzing maternal and child health needs for services, provision 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 Professional Standard Review Organizations.

The family planning program accomplishments included the development of a new reporting system and cost reporting requirements, self-instructional materials for patients, a service-integration initiative whereby family planning services were integrated with other BCHS programs, and medical care guidelines and mechanisms for improving project performance.

The migrant health activities in 1976 were directed to the continued development of health services for migrant and seasonal farmworkers, implementation of a program to improve environmental sanitation, and a national record retrieval and referral system.

National health service corps staff continued to recruit and match health professionals. Approximately 551 such professionals were active in 270 sites in 1976. Essential operational technical assistance was provided to both on-going and newly-staffed sites.

Objectives for 1977: The Bureau of Community Health Services staff will be placing primary emphasis on maximizing the use of the reduced resources proposed for the project grants for fiscal year 1977. This is necessary to maintain existing health care services to maximum extent possible. This effort is particularly significant for the people currently being served by community health centers, family planning projects, and migrant health projects.

Major efforts will also continue in relation to the following activities: Technical assistance will be provided to States with regard to implementation of maternal and child health activities, including improved project management and increased third-party reimbursements; the designation of critical health manpower shortage areas and the assignment of national health service corps health professionals to the extent provided by the 1977 budgeted level for the activity; the provision of pre-operational and post-operational technical assistance to approved and matched national health service corps sites; coordination of those programs participating in the rural health initiative; implementation of program indicators and reporting requirements in relation to community health centers, migrant health, and family planning projects.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Program management - Bureau of Medical Services (PHS Act, Section 301)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 123 | $3,509,000 | Indefinite | 123 | $3,494,000 |

Purpose: This activity provides for the overall planning, direction, and administration of the Bureau of Medical Services' program--Patient Care, Federal Employee Health, Payment to Hawaii, Buildings and Facilities, and Emergency Medical Services.

Explanation: Program direction and management services are provided for all of the Bureau'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 provide grant administration and a full range of technical assistance and program guidance to present and potential communities and recipients of grants and contracts.

Accomplishments in 1976: Program guidance and services were provided to: (1) more effectively administer the program for delivering health care services to Public Health Service beneficiaries; (2) further implement and improve occupational health programs for Federal employees; and (3) continue the initial progress being made in bringing more and better emergency medical care systems to the Nation.

Objectives for 1977: With the plan to propose legislation to authorize the transfer to community use or the closure of the eight PHS general hospitals, special emphasis will be placed on administering a contract care program to provide hospital services for PHS beneficiaries after closure of the PHS hospitals. Plans will also be developed and implemented for the orderly disposition of the Federally-owned PHS hospitals, upon closure.

Program management and services will continue to be provided the Carville Leprosarium and PHS outpatient clinics, the Federal Employee Health program, and the Emergency Medical Services activity.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Program Management - Office of the Administrator (PHS Act, Section 301)

| 1976 Appropriation | | | 1977 Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | Authorization | Pos. | Amount |
| 177 | $3,970,000 | Indefinite | 177 | $3,963,000 |

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 related costs to provide management support for the Health Services Administration's programs.

Accomplishments in 1976: The Office of the Administrator provides policy guidance and evaluation of Agency progress in achieving its objectives to all programs with concentration on overseeing major new program initiatives. These includes Health Maintenance Organizations, Professional Standards Review Organizations, Emergency Medical Services Systems, and emphasis on improving project grant management and increasing third-party reimbursements. Programs for Hypertension, Home Health and Hemophalia were also initiated.

Objectives for 1977: 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, improved project grant management, and third-party requirements.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Program Management - Payment to GSA

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $4,255,000 | Indefinite | --- | $3,380,000 |

Purpose: This activity provides rental payments to GSA for programs funded from the Health Services appropriation.

Explanation: This activity provides direct payment to GSA.

Accomplishments in 1976: Funds were provided to support the rental payments to GSA.

Objectives for 1977: Payment to the General Services Administration for rent will continue to be provided. However, rent is included for the Public Health Service hospitals and clinics for only a portion of fiscal year 1977.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services[1/]

| States | 1975 Actual | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| Alabama | $1,655,300 | $1,658,900 | --- |
| Alaska | 402,400 | 402,800 | --- |
| American Samoa | 265,700 | 257,900 | --- |
| Arizona | 1,001,200 | 1,038,200 | --- |
| Arkansas | 1,086,900 | 1,074,200 | --- |
| California | 6,813,200 | 6,926,100 | --- |
| Colorado | 1,102,200 | 1,126,800 | --- |
| Connecticut | 1,243,400 | 1,246,200 | --- |
| Delaware | 478,300 | 477,400 | --- |
| District of Columbia | 513,100 | 514,900 | --- |
| Florida | 2,882,900 | 3,009,300 | --- |
| Georgia | 2,005,500 | 2,032,000 | --- |
| Guam | 319,800 | 301,000 | --- |
| Hawaii | 561,500 | 567,500 | --- |
| Idaho | 578,800 | 582,400 | --- |
| Illinois | 3,803,500 | 3,756,700 | --- |
| Indiana | 2,091,100 | 2,073,400 | --- |
| Iowa | 1,285,500 | 1,224,300 | --- |
| Kansas | 1,059,800 | 1,032,800 | --- |
| Kentucky | 1,542,500 | 1,546,800 | --- |
| Louisiana | 1,713,600 | 1,717,900 | --- |
| Maine | 681,800 | 686,000 | --- |
| Maryland | 1,599,200 | 1,600,700 | --- |
| Massachusetts | 2,162,200 | 2,181,800 | --- |
| Michigan | 3,188,200 | 3,176,100 | --- |
| Minnesota | 1,622,900 | 1,584,500 | --- |
| Mississippi | 1,217,100 | 1,226,200 | --- |
| Missouri | 1,915,900 | 1,913,000 | --- |
| Montana | 553,400 | 552,000 | --- |
| Nebraska | 819,700 | 799,500 | --- |
| Nevada | 471,300 | 477,800 | --- |
| New Hampshire | 569,900 | 576,700 | --- |
| New Jersey | 2,576,700 | 2,562,800 | --- |
| New Mexico | 713,700 | 727,000 | --- |
| New York | 5,945,100 | 5,953,400 | --- |

1/ Allocations are awarded to States based on population and per capita income with a minimum program requirement.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services[1]/

| States | 1975 Actual | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| North Carolina | $2,207,600 | $2,229,100 | --- |
| North Dakota | 533,100 | 498,600 | --- |
| Ohio | 3,849,200 | 3,842,100 | --- |
| Oklahoma | 1,263,600 | 1,267,300 | --- |
| Oregon | 1,056,100 | 1,065,500 | --- |
| Pennsylvania | 4,266,000 | 4,236,200 | --- |
| Puerto Rico | 2,160,700 | 2,003,500 | --- |
| Rhode Island | 623,100 | 616,000 | --- |
| South Carolina | 1,334,300 | 1,355,900 | --- |
| South Dakota | 550,500 | 533,000 | --- |
| Tennessee | 1,820,100 | 1,821,100 | --- |
| Texas | 4,458,500 | 4,489,500 | --- |
| Trust Territory | 454,800 | 452,600 | --- |
| Utah | 722,400 | 733,000 | --- |
| Vermont | 470,100 | 473,600 | --- |
| Virgin Islands | 265,700 | 259,800 | --- |
| Virginia | 1,933,300 | 1,949,500 | --- |
| Washington | 1,441,400 | 1,438,000 | --- |
| West Virginia | 968,300 | 971,600 | --- |
| Wisconsin | 1,859,000 | 1,856,500 | --- |
| Wyoming | 418,900 | 422,600 | --- |
| 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 1975-7

| States | 1975 [2/] Actual | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| Alabama | $4,159,000 | $4,509,600 | $3,456,600 |
| Alaska | 368,000 | 444,000 | 324,000 |
| American Samoa | 100,000 | 166,400 | 163,500 |
| Arizona | 1,372,000 | 1,692,800 | 1,475,700 |
| Arkansas | 2,281,000 | 2,534,700 | 2,057,900 |
| California | 10,313,000 | 10,171,100 | 7,919,700 |
| Colorado | 1,658,000 | 1,668,500 | 1,422,800 |
| Connecticut | 1,454,000 | 1,402,600 | 1,055,700 |
| Delaware | 578,000 | 583,400 | 445,700 |
| District of Columbia | 478,000 | 497,000 | 374,900 |
| Florida | 5,273,000 | 5,588,200 | 4,572,500 |
| Georgia | 5,424,000 | 6,159,700 | 4,911,400 |
| Guam | 264,000 | 306,600 | 288,800 |
| Hawaii | 687,000 | 554,400 | 480,300 |
| Idaho | 788,000 | 922,700 | 823,500 |
| Illinois | 5,817,000 | 6,050,400 | 4,752,500 |
| Indiana | 4,417,000 | 4,766,700 | 3,761,500 |
| Iowa | 2,436,000 | 2,511,900 | 1,913,600 |
| Kansas | 1,591,000 | 1,604,100 | 1,254,200 |
| Kentucky | 3,893,000 | 4,493,000 | 3,499,100 |
| Louisiana | 4,396,000 | 4,687,500 | 3,676,400 |
| Maine | 1,139,000 | 1,310,200 | 1,006,000 |
| Maryland | 3,606,000 | 3,626,800 | 2,713,300 |
| Massachusetts | 2,935,000 | 3,093,600 | 2,348,200 |
| Michigan | 6,692,000 | 6,666,600 | 5,217,800 |
| Minnesota | 3,112,000 | 3,137,700 | 2,453,000 |
| Mississippi | 3,475,000 | 3,789,000 | 2,951,800 |
| Missouri | 3,827,000 | 4,146,700 | 3,408,500 |
| Montana | 696,000 | 810,500 | 663,000 |
| Nebraska | 1,171,000 | 1,269,500 | 1,029,400 |
| Nevada | 372,000 | 383,400 | 326,300 |
| New Hampshire | 666,000 | 801,300 | 629,700 |
| New Jersey | 3,645,000 | 3,303,000 | 2,631,900 |
| New Mexico | 1,123,000 | 1,292,500 | 1,067,600 |
| New York | 8,712,000 | 9,747,400 | 7,427,900 |
| North Carolina | 6,110,000 | 6,885,500 | 5,467,200 |
| North Dakota | 668,000 | 611,200 | 493,200 |
| Ohio | 7,749,000 | 8,581,600 | 6,543,100 |
| Oklahoma | 2,064,000 | 2,389,000 | 1,913,900 |
| Oregon | 1,893,000 | 1,934,900 | 1,587,800 |

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services (Cont'd)

Actual and Estimated Awards[1]
Fiscal Years 1975-7

| States | 1975 [2] Actual | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| Pennsylvania | $8,464,000 | $9,275,300 | $7,059,500 |
| Puerto Rico | 4,592,000 | 5,635,800 | 5,105,500 |
| Rhode Island | 547,000 | 515,800 | 407,400 |
| South Carolina | 3,781,000 | 4,309,700 | 3,425,600 |
| South Dakota | 734,000 | 793,700 | 639,500 |
| Tennessee | 4,015,000 | 4,413,300 | 3,440,400 |
| Texas | 8,741,000 | 9,790,200 | 7,642,700 |
| Trust Territory | 342,000 | 448,400 | 435,900 |
| Utah | 1,424,000 | 1,580,900 | 1,482,000 |
| Vermont | 561,000 | 658,100 | 497,400 |
| Virgin Islands | 248,000 | 230,000 | 191,800 |
| Virginia | 4,318,000 | 4,647,000 | 3,579,800 |
| Washington | 2,919,000 | 2,953,900 | 2,286,400 |
| West Virginia | 2,008,000 | 2,393,000 | 1,909,800 |
| Wisconsin | 3,496,000 | 3,754,500 | 2,914,600 |
| Wyoming | 330,000 | 377,000 | 319,300 |
| Total distribution by formula [1] | 163,922,000 | 176,872,500 | 139,847,500 |
| Special projects for mentally retarded children | 4,708,000 | 4,750,000 | 3,420,000 |
| Other special projects | 7,973,000 | 8,937,217 [3] | 3,926,500 |
| Total | 176,603,000 | 190,559,717 | 147,194,000 |

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 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 1977 figures represent tentative apportionment of the amount requested.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services(Cont'd)

Actual and Estimated Awards1/
Fiscal Years 1975-7

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.

3/ Excludes $1,500,000 for program support.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services

Actual and Estimated Awards [1/]
Fiscal Years 1975-7

| State | 1975 Actual[2/] | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| Alabama | $1,338,000 | $1,527,500 | $889,500 |
| Alaska | 192,000 | 202,900 | 176,100 |
| American Samoa | 81,000 | 147,600 | 144,400 |
| Arizona | 579,000 | 610,500 | 372,700 |
| Arkansas | 783,000 | 925,100 | 540,700 |
| California | 2,845,000 | 3,468,400 | 2,106,100 |
| Colorado | 564,000 | 656,000 | 390,100 |
| Connecticut | 567,000 | 640,800 | 406,500 |
| Delaware | 224,000 | 236,500 | 193,300 |
| District of Columbia | 245,000 | 248,400 | 199,600 |
| Florida | 1,547,000 | 1,829,800 | 1,106,000 |
| Georgia | 1,597,000 | 1,916,700 | 1,133,700 |
| Guam | 165,000 | 158,700 | 152,100 |
| Hawaii | 254,000 | 277,700 | 219,000 |
| Idaho | 340,000 | 347,200 | 218,700 |
| Illinois | 1,893,000 | 2,231,500 | 1,307,900 |
| Indiana | 1,515,000 | 1,789,800 | 1,055,700 |
| Iowa | 897,000 | 1,039,800 | 585,200 |
| Kansas | 577,000 | 674,400 | 391,600 |
| Kentucky | 1,272,000 | 1,464,000 | 848,100 |
| Louisiana | 1,314,000 | 1,578,700 | 907,700 |
| Maine | 259,000 | 452,800 | 267,500 |
| Maryland | 861,000 | 1,005,500 | 596,200 |
| Massachusetts | 980,000 | 1,232,300 | 727,000 |
| Michigan | 2,121,000 | 2,457,600 | 1,446,600 |
| Minnesota | 1,103,000 | 1,299,000 | 752,900 |
| Mississippi | 1,073,000 | 1,253,800 | 741,600 |
| Missouri | 1,206,000 | 1,416,000 | 842,300 |
| Montana | 291,000 | 299,000 | 209,000 |
| Nebraska | 439,000 | 508,700 | 299,600 |
| Nevada | 237,000 | 230,100 | 193,500 |
| New Hampshire | 297,000 | 298,700 | 213,400 |
| New Jersey | 1,116,000 | 1,275,800 | 771,500 |
| New Mexico | 411,000 | 468,400 | 279,600 |
| New York | 2,594,000 | 3,220,500 | 1,968,800 |

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1975-7

| State | 1975 Actual 2/ | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| North Carolina | $2,029,000 | $2,412,500 | $1,407,100 |
| North Dakota | 256,000 | 275,300 | 199,600 |
| Ohio | 2,517,000 | 3,000,500 | 1,747,300 |
| Oklahoma | 738,000 | 886,500 | 532,900 |
| Oregon | 607,000 | 712,400 | 421,800 |
| Pennsylvania | 2,814,000 | 3,333,000 | 1,924,600 |
| Puerto Rico | 1,484,000 | 1,925,300 | 1,255,900 |
| Rhode Island | 296,000 | 286,600 | 219,700 |
| South Carolina | 1,132,000 | 1,360,300 | 797,800 |
| South Dakota | 258,000 | 318,600 | 204,000 |
| Tennessee | 1,367,000 | 1,624,300 | 929,400 |
| Texas | 2,859,000 | 3,422,200 | 2,034,000 |
| Trust Territory | 165,000 | 164,600 | 155,500 |
| Utah | 341,000 | 427,000 | 268,100 |
| Vermont | 249,000 | 254,200 | 184,300 |
| Virgin Islands | 166,000 | 154,000 | 150,200 |
| Virginia | 1,402,000 | 1,631,700 | 956,700 |
| Washington | 813,000 | 959,100 | 562,300 |
| West Virginia | 755,000 | 870,700 | 502,200 |
| Wisconsin | 1,324,000 | 1,579,400 | 905,500 |
| Wyoming | 188,000 | 199,100 | 173,900 |
| Total distribution by formula 1/ | 53,537,000 | 63,187,500 | 38,187,000 |
| Special projects for mentally retarded children | 4,999,000 | 5,000,000 | 3,600,000 |
| Other special projects | 6,357,000 | 8,312,500 | 4,941,000 |
| Total | 64,893,000 | 76,500,000 | 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 1975-7

(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 1977 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.

HEALTH SERVICES ADMINISTRATION

Supplemental Allocations of Grants for Maternal and Child Health Services

Estimated Awards
Fiscal Years 1975-7

| States | 1975 Actual | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| Alabama | $202,836 | $21,657 | --- |
| Alaska | --- | --- | --- |
| American Samoa | --- | --- | --- |
| Arizona | 166,259 | --- | --- |
| Arkansas | --- | --- | --- |
| California | --- | --- | --- |
| Colorado | 1,567,721 | 2,019,260 | --- |
| Connecticut | 295,159 | 353,388 | --- |
| Delaware | --- | --- | --- |
| District of Columbia | 3,282,814 | 4,437,134 | --- |
| Florida | 968,979 | 685,700 | --- |
| Georgia | --- | --- | --- |
| Guam | --- | --- | --- |
| Hawaii | 327,257 | 554,847 | --- |
| Idaho | --- | --- | --- |
| Illinois | 2,930,725 | 3,403.431 | --- |
| Indiana | --- | --- | --- |
| Iowa | --- | --- | --- |
| Kansas | --- | --- | --- |
| Kentucky | --- | --- | --- |
| Louisiana | --- | --- | --- |
| Maine | --- | --- | --- |
| Maryland | 2,299,237 | 2,969,732 | --- |
| Massachusetts | 1,489,285 | 1,624,126 | --- |
| Michigan | 480,528 | 279,000 | --- |
| Minnesota | --- | --- | --- |
| Mississippi | --- | --- | --- |
| Missouri | 97,755 | --- | --- |
| Montana | --- | --- | --- |
| Nebraska | 664,143 | 729,320 | --- |
| Nevada | 57,030 | 24,448 | --- |
| New Hampshire | 107,631 | --- | --- |
| New Jersey | --- | --- | --- |
| New Mexico | --- | --- | --- |
| New York | 7,379,303 | 8,398,938 | --- |

HEALTH SERVICES ADMINISTRATION

Supplemental Allocations of Grants for Maternal and Child Health Services
(Cont'd)
Estimated Awards
Fiscal Years 1975-7

| States | 1975 Actual | 1976 Appropriation | 1977 Request |
|---|---|---|---|
| North Carolina | --- | --- | --- |
| North Dakota | --- | --- | --- |
| Ohio | $239,138 | --- | --- |
| Oklahoma | --- | --- | --- |
| Oregon | --- | --- | --- |
| Pennsylvania | --- | --- | --- |
| Puerto Rico | 1,845,834 | $1,031,802 | --- |
| Rhode Island | --- | --- | --- |
| South Carolina | --- | --- | --- |
| South Dakota | --- | --- | --- |
| Tennessee | --- | --- | --- |
| Texas | 163,829 | --- | --- |
| Trust Territory | --- | --- | --- |
| Utah | --- | --- | --- |
| Vermont | --- | --- | --- |
| Virgin Islands | 434,537 | 607,500 | --- |
| Virginia | --- | --- | --- |
| Washington | --- | --- | --- |
| West Virginia | --- | --- | --- |
| Wisconsin | --- | --- | --- |
| Wyoming | --- | --- | --- |
| Total | $25,000,000 | 27,140,283 | --- |

New Positions Requested

| | Grade | 1977 Number | 1977 Annual Salary |
|---|---|---|---|
| National Health Service Corp | | | |
| Medical Officer | GS-13 | 3 | $82,725 |
| Dental Officer | GS-13 | 2 | 55,150 |
| Nurse practitioner | GS-9 | 9 | 115,884 |
| Nurse practitioner | GS-7 | 11 | 119,482 |
| Subtotal | | 25 | 373,421 |
| Medical Officer | Full | 35 | 542,920 |
| Dental Officer | Full | 8 | 124,096 |
| Medical Officer | Senior Assistant | 40 | 570,720 |
| Dental Officer | Senior Assistant | 13 | 185,484 |
| Commissioned Nurse Officer | Senior Assistant | 4 | 57,072 |
| Subtotal | | 100 | 1,480,292 |
| Total New Positions | | 125 | 1,853,713 |
| Professional Standards Review Organizations | | | |
| Public Health Program Specialist. | GS-15 | 1 | $ 31,309 |
| Medical Care Administrator | GS-14 | 1 | 26,861 |
| Nurse | GS-14 | 1 | 26,861 |
| Public Health Program Specialist. | GS-14 | 1 | 26,861 |
| Public Health Program Specialist. | GS-13 | 5 | 114,530 |
| Medical Care Administrator | GS-13 | 4 | 91,624 |
| Health Economist | GS-13 | 1 | 22,906 |
| Public Health Program Specialist. | GS-12 | 10 | 193,860 |
| Public Health Program Specialist. | GS-11 | 5 | 81,275 |
| Program Analyst | GS-9 | 3 | 40,446 |
| Clerical Assistant | GS-7 | 3 | 33,138 |
| Secretary | GS-6 | 2 | 19,892 |
| Clerical Assistant | GS-5 | 5 | 44,625 |
| Clerk Typist | GS-4 | 6 | 47,856 |
| Total New Positions | | 48 | 802,044 |
| Total New Positions All Activities | | 173 | 2,655,757 |

Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Estimate | Transition Quarter |
| Community health services: | | |
| a) Community health centers | $196,648,000 | $48,000,000 |
| b) Comprehensive health grants to States | 90,000,000 | 22,500,000 |
| c) Maternal and child health: | | |
| 1) Grants to States | 295,700,000 | 65,316,000 |
| 2) SIDS | 2,500,000 | --- |
| 3) Research and training | 23,708,000 | 14,909,000 |
| Subtotal | 321,908,000 | 80,225,000 |
| d) Family planning | 100,615,000 | 7,000,000 |
| e) Migrant health | 25,000,000 | 3,500,000 |
| f) Health maintenance organizations: | | |
| 1) Grants and Contracts | 15,000,000 | 4,043,000 |
| | (15,727,000) | |
| 2) Program support | 3,612,000 | 957,000 |
| Subtotal | 18,612,000 | 5,000,000 |
| | (19,339,000) | |
| g) National health service corps | 15,000,000 | 8,662,000 |
| | (20,000,000) | |
| h) Hypertension | 3,750,000 | --- |
| i) Home health services | 3,000,000 | --- |
| j) Hemophilia | 3,000,000 | --- |
| Subtotal | 777,533,000 | 174,887,000 |
| | (783,260,000) | (174,887,000) |
| Quality assurance: | | |
| a) Medical care standards | --- | --- |
| | (5,187,000) | (1,764,000) |
| b) Professional standards review organizations | 26,448,000 | 7,754,000 |
| | (47,582,000) | (13,011,000) |
| Subtotal | 26,448,000 | 7,754,000 |
| | (52,769,000) | (14,775,000) |
| Patient care and special health services: | | |
| a) Patient care | 116,164,000 | 30,680,000 |
| | (136,056,000) | (35,659,000) |
| b) Coast Guard medical services | --- | --- |
| c) Federal employee health | 606,000 | 168,000 |
| | (6,830,000) | (1,770,000) |
| d) Payment to Hawaii | 1,200,000 | 300,000 |
| Subtotal | 117,970,000 | 31,148,000 |
| | (144,086,000) | (37,729,000) |
| Emergency medical services | 37,025,000 | 1,000,000 |
| Buildings and facilities | --- | --- |
| | (13,815,000) | (---) |
| Program management | 30,663,000 | 7,998,000 |
| Total | 989,639,000 | 222,787,000 |
| | (1,061,618,000) | (236,389,000) |

Explanation

The Community Health Center's program within the Bureau of Community Health Services will require $48,000,000 in the transition quarter. This amount is necessary 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. This $22,500,000 for the Comprehensive health grants to States is one-quarter of the $90,000,000 request for the total year. The $65,316,000 for Maternal and Child Health is based on the funding of 151 project grants and the distribution to the States of formula grant funds. In addition, the $14,909,000 for MCH research and training is based on the funding of eight research and 26 training projects. As estimated $7,000,000 is necessary for Family Planning activities during this three-month period. This amount is based on continuing to fund 16 ongoing family planning grants. $3,500,000 will be needed by the Migrant Health program to continue the funding of 16 projects. The Health Maintenance Organizations' request for $5,000,000 is based on providing funds to five developmental projects totaling $4,043,000 and $957,000 for program support. An estimated $8,662,000 is requested for the National Health Service Corps for the transitional period. This amount is due to the estimate being based on 676 positions rather than 405 positions and the fact that a large number of physicians will be eligible for the commissioned officer's bonus pay.

The Professional Standards Review Organization program within the Bureau of Quality Assurance will require $7,754,000 in this three-month period. This amount will be used to meet commissioned officer's bonus pay requirements and for anticipated contracts which will need refunding during the transition quarter.

The Bureau of Medical Services' Patient Care activity will require $30,680,000 between July 1, and September 30, 1976. This amount is needed for commissioned officer's pay, increases in contract medical care, within grade and longevity increases, and for changes in rates such as utilities and postage. An estimated $168,000 is needed for the Federal Employee Health program. This amount is required to carry out this program during the transition quarter, plus funds for commissioned officer's bonus pay and within grade increases. The $300,000 for Hawaii is simply 25 percent of the total year funding requirement. An estimated $1,000,000 is required for the Emergency Medical Services program. This amount will be used to fund thirty grants and contracts which will receive Federal funds. Finally, a total of $7,998,000 is needed for Program Management activities during the transition quarter. This amount, besides being required to carry out the normal program management functions, is needed to meet such mandatory cost increases such as commissioned officers' bonus pay, within grade and longevity increases, and for one extra day of pay.

TUESDAY, FEBRUARY 24, 1976.

# CENTER FOR DISEASE CONTROL

## PREVENTIVE HEALTH SERVICES

### WITNESSES

DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL
DR. JOHN F. FINKLEA, DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH
JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL
CLAUDE PICKELSIMER, DIRECTOR, FINANCIAL MANAGEMENT OFFICE, CENTER FOR DISEASE CONTROL
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

Mr. FLOOD. We will now have the Center for Disease Control, Preventive Health Services. The presentation, of course, will be made by Dr. David J. Sencer, the Director of the Center for Disease Control.

A biographical sketch of you, Doctor, will be placed in the record at this point.

[The biographical sketch of Dr. Sencer follows:]

Name: 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, internship; internal medicine residency, 1954; Harvard University School of Public Health, 1958, M.P.H.

Experience: 1966 to 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.; 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 Prevention 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; diplomat, American Board of Preventive Medicine; fellow, American College of Preventive Medicine; Board of Governors of the United States-Israel Binational Science Foundation.

SCIENTIFIC PUBLICATIONS

Comstock, C. W., Kaltz, H., and Sencer, D. J.: Clay eating and sarcoidosia. A controlled study in the State of Georgia. Am. Rev. Resp. Dis. 84:130–134, 1961.

Sencer, David J.: Followup: services for nonhospitalized patients—the national picture. Dull. Natl. TB Assoc. 51:13–15, 1965.

Sencer, David J.: Management of tuberculosis in the general hospital. In Proc. of Institute on Control of Infections in Hospitals held at University of Michigan, Ann Arbor, Mich., March 1–3, 1965, pp. 119–122.

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.

Sencer, David J.: A program to eradicate measles (editorial), Am. J.P.H. *57*: 729–730, 1967.

Sencer, David J.: Public understanding of the health sciences. Ann. N.Y. Acad. Sci., 142: 539–542, 1967.

Sencer, David J.: Health protection in a shrinking world. Am. J. Trop. Med. *18*: 341–345, 1969.

Sencer, David J., Witte, J. J., Krachmer, A. W.: The epidemiology of rubella in the United States. In Proc. International Symposium on Rubella Vaccine. Symp. Series Immunobiol. Standard. Vol. 11, Basel/New York, Karger, 1969, pp. 9–14.

Sencer, David J. and Staff of Laboratory Division and Epidemiology Program: Emerging diseases of man and animals. Ann. Rev. Microbiol. *25*: 465–486, 1971. In press.

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. You have some people with you

Dr. SENCER. Yes; Mr. Miller at the far right, and Dr. Finklea who is the Director, National Institute for Occupational Safety and Health; Mr. Bloom, executive officer of the Center; and Mr. Pickelsimer, our financial management officer.

Mr. FLOOD. I see you have a prepared statement. How do you want to handle it?

Dr. SENCER. I would like to present it, if it is agreeable.

Mr. FLOOD. Very well.

## STATEMENT BY DIRECTOR, CENTER FOR DISEASE CONTROL

Dr. SENCER. Mr. Chairman, members of the committee, it is a pleasure to present the budget for Preventive Health Services for fiscal year 1977.

The Center for Disease Control is the Nation's primary Federal focus for programs directed at preventing diseases and their consequences. Beginning with a mandate for control of just one disease—malaria—in the 1940's, CDC's mission has been broadened so that today it includes a variety of programs all directed at protecting the health of the American public.

To summarize our activities, I have categorized them into five major areas: (1) investigation, surveillance and control of disease; (2) activities to improve the safety and health of workers; (3) improvements in disease control techniques; (4) health education, and (5) laboratory improvement.

### INVESTIGATING, SURVEILLANCE, AND CONTROL OF DISEASE

The major portion of the Preventive Health Services budget is directed at investigation, surveillance, and control of disease. Working with State and local health departments, we maintain active surveillance and control programs for more than 30 diseases.

During 1975, our staff conducted more than 1,500 separate investigations of disease conditions. These investigations ranged from national epidemics, such as the current epidemic of influenza, involving thousands of people, to a single occurrence of a disease not common to this country, such as leishmaniasis or Chagas' disease.

The arrival in this country of more than 100,000 Vietnamese refugees required a major effort by CDC in 1975. We immediately established a surveillance program at camps in the Far East and in this country to assure that the conditions of camp life would not cause disease, and that emerging problems were promptly corrected. Arriving refugees were screened for personal and potential public health problems. Children were immunized against the vaccine-preventable diseases. We found few unexpected health problems among the refugees and were able to assure the American public that these new citizens posed no more of a problem to the public health than any of the other thousands of immigrants who come to this country every year. We are proud that 230 of our staff actively worked for varying periods of time in this humanitarian effort.

Cases of mosquito-borne encephalitis reached an alltime high in the United States during 1975. Approximately 2,000 cases and 100 deaths were reported. Activity was the most widespread ever, as 35 States and the District of Columbia had cases of encephalitis. Four of these States—Illinois, Indiana, Mississippi, and Ohio—had more than 100 cases. CDC provided technical assistance in identifying suspect cases and in controlling the mosquitoes which transmit the disease. We are continuing our investigation of this year's epidemic, so that appropriate control measures can be recommended for future years.

Hospital-acquired infections continue to be a major problem. We estimated that 1½ million patients spend an additional 7 days in a hospital each year because of such an infection. The cost is a staggering $1 billion. Now underway is a major study to determine which hospital infection control procedures are most effective. This "Study on the Efficacy of Nosocomial Infection Control" will be largely completed during fiscal year 1977. It will give us information we need to assist hospitals in developing effective infection surveillance and control procedures to reduce the human suffering and economic loss resulting from this problem.

During this past year, we have expanded birth defects monitoring to a national scope. This program will now cover approximately 1 million births a year. It should give us a data base large enough to uncover changes in the incidence of birth defects and the types of environment or other exposure which might be responsible.

Progress continues to be made in preventing the dread diseases of the young, such as polio, diphtheria, tetanus, whooping cough, rubella, mumps, and measles.

Reported cases of measles remained below 25,000 for the past 2 years—a sharp decline from the 400,000-plus cases occurring less than 10 years ago. The number of cases of congenital rubella, characterized by deafness and blindness and other defects, reached an alltime low. Only six cases of polio were reported in 1975, compared to thousands of cases and deaths some 20 years ago.

More than 440,000 children were tested for excess lead in their bodies. Of those tested 28,000 had potentially dangerous levels of lead and were provided with medical and environmental services to protect them from the serious consequences of lead poisoning. In cooperation with the American Academy of Pediatrics, lead screening guidelines were developed for the early periodic screening, diagnosis and treatment (EPSDT) programs. While a national figure on the number of children screened under EPSDT programs is not available, we are

aware of at least 275,000 children who were tested for excess lead. Seventeen States now require a screening test for lead under EPSDT, and 32 States have a reimbursement procedure. At the State and local levels, we are encouraging maternal and child health programs, Head Start programs, neighborhood health centers, and children and youth projects to do lead screening where appropriate.

Rat control programs were carried out in the neighborhoods of more than 5½ million urban Americans. In these neighborhoods, 64 percent of the blocks were certified as being essentially rat free.

The incidence of gonorrhea and syphilis remain at unacceptable high levels. Gonorrhea is still the most frequently reported infectious disease in this country, although the percentage of increase has been slowed. More than 8 million women were tested for gonorrhea last year. Of these, 375,863 or 4.2 percent had gonorrhea and were treated. Early identification makes it possible to prevent further spread of the disease.

Syphilis increased slightly during the past year, although major increases were confined to a few areas of the country and largely limited to males. Major efforts are underway to tailor venereal disease control services to assure acceptance by the homosexual population.

We will continue to generate other sources of support for control programs directed at the vaccine-preventable diseases, veneral diseases, rats, and lead poisoning. An example of such additional support is the $4,847,228 made available in fiscal year 1976 to grantees from the job opportunities program of the Public Works and Economic Development Act.

### HEALTH AND SAFETY OF WORKERS

The Federal initiative in occupational health is a very old one. It began in 1914 with the establishment of the Office of Industrial Hygiene and Sanitation "to study the health problems in the Nation's expanding industrial economy."

Increased impetus to improving conditions for workers was given in 1970, with the passage of the Occupational Safety and Health Act. The National Institute for Occupational Safety and Health (NIOSH) was created by this act as the principal Federal agency engaged in research to eliminate job hazards for America's working population. It is NIOSH's primary responsibility to identify occupational safety and health hazards and to develop recommendations regarding new hazards and changes in existing regulations. During 1975, significant progress was made by NIOSH in accomplishing this mission.

NIOSH transmitted nine recommended standards to the Department of Labor. These standards evaluated the occupational health hazards posed by benzene, chloroform, cotton dust, silica, ammonia, fluorides, xylene, arsenic, and labeling of hazardous materials. Laboratory research in support of criteria development for the standards recommendation program is directed at 32 hazardous substances and physical agents. Industrywide studies in support of the standards recommendation program are being conducted in 37 different industries.

NIOSH completed 65 health hazard evaluation reports. Such evaluations are designed to determine if substances normally found in a

specific place of employment have potentially toxic effects. They are made on request from an employer or a representative of employees.

Coal miner chest X-rays for 55,000 workers were processed as part of the medical examination program mandated by the Federal Coal Mine Health and Safety Act of 1969.

Training in occupational safety and health was given to 1,200 individuals as part of the NIOSH reimbursable short-term training program. Development continued on the packaging of courses for presentation by others as well as development of correspondence courses.

Tests were done on 272 different models of personal protective equipment.

Significant progress has been made in the development of an occupational carcinogenesis program within NIOSH. In cooperation with the National Cancer Institute, we have initiated epidemiologic studies involving possible environmental or occupational exposures and the excess lung, mouth, and throat cancer mortality rates noted in selected Georgia and South Carolina counties. It is significant that the number of investigations by CDC epidemiologists of diseases caused by environmental factors such as lead and kepone—increased threefold this past year.

NIOSH personnel in Cincinnati are being moved from the unsatisfactory facilities we have been occupying to two new locations in that city. The majority of our operations in Cincinnati will be moved by spring.

During 1976, NIOSH will recommend to the Department of Labor criteria on 24 hazardous substances that impinge on the health of 1.7 million people in the workplace. The budget will also permit NIOSH to carry out increased research on hazardous substances and harmful physical agents and allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiologic investigations in 40 high-risk industries, as compared with 37 in 1976.

### DEVELOPMENT OF NEW DISEASE CONTROL TECHNIQUES

A major activity supported under the Preventive Health Service budget is a program to improve techniques used to control diseases.

A testing procedure is of little value if it is too expensive or not generally available; nor can a strategy for containment of disease be effective if those involved are not aware of the strategy. It is CDC's mission to foster the development of new tests and procedures and then promote rapid and widespread use of the improved techniques through training programs, workshops, publications, and other outreach efforts.

Areas in which we are currently attempting to improve laboratory and diagnostic proficiency include: blood lead determinations, especially in children; blood levels of digoxin, a drug used in heart disease therapy, which must be continually monitored; alkaline phosphatase which is important in the diagnosis of bone, liver and prostatic cancer; and magnesium deficiencies, which are of increasing clinical importance. In hematology, a new method for evaluating the technologist's ability to correctly read differential blood films will be employed. Review of the competency of cytotechnologists in screening

vaginal and cervical smears for cancer will continue as will a survey of national competency in identifying carcinoembryonic antigen (CEA) in serum, a relatively new test used in cancer control.

During 1975, the progressive increase in gonococcal resistance to penicillin and tetracyline was halted for the first time since it began 25 years ago. This was accomplished because of widespread use of the CDC treatment schedules for gonorrhea.

A new strategy for controlling measles outbreaks is now being field tested in one section of the country. The strategy, which is based on the procedures we have used in the worldwide war on smallpox, stresses early identification and control. If successful, it will—in combination with basic immunization programs—become the national strategy for measles control.

New serologic tests have been developed which permit identification of individuals with hepatitis. These new tests were made possible because scientists perfected a technique to recover hepatitis A virus from a common source outbreak and visualize it with an electron microscope. These accomplishments are necessary steps along the road to development of an improved test for hepatitis A and eventually a vaccine.

The emergence of different influenza strains throughout the world is monitored by the CDC's World Health Organization Collaborating Center for Influenza in cooperation with collaborating laboratories in 69 countries. Reagents distributed to nearly 200 laboratories provide uniformity in the diagnosis and analysis of influenza. To update methodology in collaborating laboratories, CDC conducted a workshop for senior scientists from eight countries in the Southeast Asia and the Western Pacific regions. The worldwide surveillance and uniform analysis of influenza isolations provides essential data for the formulation of current influenza vaccines in this and other countries. A large field trial comparing live and inactivated vaccines was conducted in nearly 1,000 volunteers during 1975. Both vaccines were effective in reducing the illness attack rate during an epidemic of influenza in the study population. Investigations of the characteristics of other live influenza virus candidate vaccine strains are in progress.

### HEALTH EDUCATION

Thousands of deaths and illnesses occur in the United States each year because the American people are not fully aware of the important role lifestyle can play in maintaining or harming health. Many premature illnesses and deaths can be prevented by decisions individuals and communities can make to protect their own health.

The activity that I would like to highlight demonstrates how we see the role of health education in the Public Health Service. CDC is collaborating with the Bureau of Quality Assurance, the Social Security Administration, and National Institute of Arthritis, Metabolic and Digestive Diseases in developing a health education program that will encourage people to donate kidneys for renal disease problems. We have demonstrations in three different communities to see if by intensive professional and public educational program we can increase the supply of donated kidneys to help meet this very serious and expensive problem.

To assure that all Americans can make informed health decisions, and to motivate them to take action to improve their health status, CDC provides coordination for a national health education program. The program encourages broad use of the Nation's health care system in its many ramifications so as to prevent unnecessary disabilities or deaths.

Research, demonstration, or evaluation projects are being carried out in cooperation with neighbrohood health centers, schools, agricultural extension services and other existing facilities. Other projects involve programs with the newly formed "National Center for Health Education," comprised of private health groups, and the continuation of surveys of smoking prevalence among teenagers, adults, and health professionals.

In 1976, a desk reference containing a summary of the significant scientific evidence and health problems related to cigarete smoking will be developed. It will provide a valuable tool for health professionals, researchers and others involved in managing health problems related to smoking.

LABORATORY IMPROVEMENT

More than 4 billion clinical tests are done annually in the laboratories of this Nation. The accuracy of these tests determines, in many cases, the quality of diagnosis, preventive care, or treatment the American citizen will receive. CDC administers a multifaceted program to improve the Nation's more than 14,000 clinical laboratories and to upgrade the quality of the tests and materials used by these laboratories. Our activities in laboratory technology development and transfer were summarized earlier in this statement.

In addition, CDC has, since passage of the Clinical Laboratory Improvement Act, utilized the regulatory process as another means of accomplishing laboratory improvement. Since that time, constant efforts have been made to meld the CLIA and the medicare laboratory certification process so that the programs are uniform and nonduplicative. In the interest of economy and effectiveness and to insure maximum uniform coverage of the Nation's approximately 14,000 clinical laboratories, CDC has entered into an agreement with the Social Security Administration and the Health Services Administration which provides for an integration of functions. CDC assumes the responsibility for oversight monitoring of the effectiveness of each State program and other approved programs, including those of the College of American Pathologists, and the Joint Commission on the Accreditation of Hospitals. States will be expected to provide or approve a proficiency testing program equivalent to the performance evaluation program applied to CLIA laboratories. CDC will provide proficiency testing for CLIA and medicare laboratories where States do not have equivalent programs. In the event that the monitoring program finds some part of a State evaluation program less stringent than that of CLIA, CDC will directly evaluate all medicare and CLIA laboratories in that State until the State evaluation program can be upgraded. CDC will continue to initiate scientific and technical standards for application to both CLIA and medicare laboratories in the areas of personnel, quality control, and proficiency testing.

Additional resources in 1977 would allow CDC to carry out its responsibilities under these agreements, including increased on-site

surveillance of laboratories, proficiency testing services for 1,500 laboratories not presently covered, and increased assistance in the development of State training capabilities. The Center also would provide financial assistance to States which have demonstrated a real interest in upgrading their intrastate programs. Such assistance, when extended to all States, would provide for the full gamut of laboratory improvement activities from regulatory monitoring to technical training and consultation designed to insure adherence by clinical laboratories to minimal levels of performance, regardless of size, type, or geographical location.

Finally, I would like to bring you up to date on the world-wide effort to eliminate smallpox. While our activities against this disease have been only partially funded by this appropriation, this committee and its members have been most supportive of our efforts. Within the past few months, smallpox has been eradicated from India and Bangladesh. This dread disease is now confined to the central Ethiopian highlands where accelerated efforts are underway to bring about the demise of smallpox in 1976.

Mr. Chairman, I will be happy to answer any questions that you or other members of the committee may have.

### IMMUNIZATION

Mr. FLOOD. The President's budget states one of your responsibilities is the surveillance of the immunization status of the population.

Dr. SENCER. Yes, sir. That is correct.

Mr. FLOOD. What can you tell us about the current immunization level? What is the level for the entire Nation?

Dr. SENCER. We only maintain a surveillance of immunization in children. By the time people have reached adulthood they usually have had the diseases with which we are concerned. I am sorry I can't give you the 1975 figures because they haven't come from the Bureau of the Census. The 1974 figures are: poliomyelitis, 63 percent of the pre-school children have had adequate immunization; against diphtheria, tetanus and pertussis, 74 percent; measles, 65 percent; and German measles, 65 percent.

### COORDINATION OF IMMUNIZATION

Mr. FLOOD. In your justification you state there is going to be a considerably lower immunization level among various population subgroups, among the urban and rural poor.

Doctor, several programs other than your own have responsibilities for providing this kind of service, for example, community health centers, the National Health Service Corps, the migrant health program, medicaid. It would seem to all of us if all these programs were doing their job, we would have a better immunization record. Can you tell us who isn't doing their job?

Dr. SENCER. Many of the programs you mentioned, sir, are programs that people use mainly when they are sick. The problem we face with immunization is getting people to come to the service, as in the outreach activities of working in housing projects in the central cities.

Mr. FLOOD. What we want to know is how they coordinate the programs.

Dr. SENCER. Most of these programs are coordinated at the State and local level. We know that in all the neighborhood health centers supported by Public Health Service funds, the State health departments make vaccines available free of charge to all of these programs. With the maternal and child health programs we frequently will find at the end of the fiscal year in many States there is some Maternal and Child Health money left over that we can use for vaccine purchases through our centralized contract. Most coordination is at the State and local levels where the vaccines and activities are made available.

Mr. FLOOD. What plans do you have to improve these immunization levels in 1977?

Dr. SENCER. We have evidence or we think we have evidence—I won't be too sure of this until we see the 1975 figures—that a program that was initiated in 1974 called Immunization Action Month, proved to be an effective way to get immunization levels up. In this program we have the cooperation of the American Medical Association, the Academy of Pediatrics, the State and territorial health officers, HEW, and industry, all working to put on a concerted effort in the month of October to assure that each child's immunization record is audited and that where deficiencies are found, an organized attempt is made to correct them. The first year of this program did see a reversal of the steady downward path of immunization levels in the country, and we anticipate that 1975 will continue to be on the upswing. We have plans to continue this program in the coming October.

VENEREAL DISEASES

Mr. FLOOD. Your budget on the VD program assumes a greater financial support from the State and local governments. What has been your experience so far this year in getting these State and local governments to support the VD control activity?

Dr. SENCER. We have not had overwhelming success in this area, as I am sure you know. The State budgets are also having difficulty, and we are doing our best to make sure that efforts are at least maintained in the areas of veneral disease, immunization, and lead-based paint control.

Mr. FLOOD. Again, your budget justification shows that syphilis still increases. Do I recall a conversation we had a few years ago in which you thought reduction in the incidence of this disease was going to be accomplished? Have we run out of ways to combat and control this disease?

Dr. SENCER. No; we have very effective ways of controlling syphilis. As I mentioned in my opening statement, the increase is pretty much limited to 2 areas of the country. These are Florida and California.

The rate of syphilis in women is going down, whereas in men it is going up. We are taking some new approaches to this problem to see if we can provide preventive services to a population group that does not usually get into the health care system.

Mr. FLOOD. Will this budget allow you to expand your VD control activities?

Dr. SENCER. No; it won't allow for any expansion, but we hope we will be able to keep the same level of activity going.

ST. LOUIS ENCEPHALITIS

Mr. FLOOD. During this past summer the country experienced a very serious outbreak of this St. Louis encephalitis. What steps are you taking to insure that we will not have a repeat of this situation the coming summer? There is no mystery that the best way to handle the thing is by mosquito control.

Dr. SENCER. Yes. We feel that in urban areas most mosquito abatement efforts should be a part of community activities. We do work with local areas in developing these. It is becoming more difficult now, and I think appropriately so, that we have to go to ecological modification programs rather than the wide use of insecticides. The problem last summer was compounded by the very heavy floods and rains we had in the upper Mississippi. There is really not much, with modern technology, that can be done to prevent mosquitoes from spreading in the large rural areas, as they did in the Dakotas and Minnesota last year. We have an active research program trying to find ways of predicting when virus activity will spill over from birds into man. The mosquito transmits the virus from bird to bird, and when the virus builds up in the bird population, it will spill over into man. Some of the newer techniques in virology are such that we can attempt to see if it is feasible to think of a vaccine against St. Louis encephalitis. I would not hold out any immediate hopes for this.

LEAD-BASED PAINT POISONING

Mr. FLOOD. Last year we asked you to more than double your efforts to encourage other health service programs over at HEW to perform routine screening of children in connection with lead poisoning. Would you like to report your progress in this area.

Dr. SENCER. We have been quite successful in this area. We have worked principally with Social and Rehabilitative Services in early, periodic screening, and diagnostic and treatment programs. As you may know, there are no national figures available under the EPSDT programs, but our contracts in the States report that at least 275,000 children have been screened.

Mr. FLOOD. What about other programs such as, maternal and child health, the neighborhood health center programs, medicaid, etc. What about their activities?

Dr. SENCER. Yes; last year we developed a new methodology for doing the screening. We have made this available to all the other providers within HEW. This is a cheaper method and we are able to not only test for lead poisoning but also for a variety of anemias. We do think this is being incorporated into all the other provider services that aim at children.

Mr. FLOOD. How many children do you screen under the lead-base paint poisoning program? How many children in the other programs such as maternal health and children were screened in fiscal 1976?

Dr. SENCER. We do know of at least 275,000.

Mr. FLOOD. Do all the States have laboratories with lead analysis capabilities?

Dr. SENCER. There are 32 States.

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Mr. FLOOD. Do they or don't they?

Dr. SENCER. Not all States have the capability but there are arrangements whereby they could——

Mr. FLOOD. How many don't have?

Dr. SENCER. I think there are 17 States that do not have capability at the present time.

Mr. FLOOD. What needs to be done to develop the capability?

Dr. SENCER. I think that in some of these States, sir, it would not be feasible to develop the capability. In certain instances, it is probably more economical to use other laboratories than to try to develop your own capability to perform lead analyses. If you are not going to be doing a large volume of tests, particularly in those areas where lead-based paint has not been used, you would be investing in a capability that would not be adequately used.

Mr. FLOOD. Several years ago we kept hearing that this lead screening procedure was very, very expensive. What have you done to reduce the cost of this?

Dr. SENCER. There has been a new test developed which can be done on a drop of finger blood, called the erythrocyate protoporphyrin test, which has reduced the cost of doing the laboratory determination from $3 to around 50 cents.

Mr. FLOOD. You stated that the number of children treated for lead poisoning decreased in 1975 while the number of children identified with a lead problem increased 76 percent. Is this trend continuing? If so, where is it?

Dr. SENCER. I am not familiar with that particular figure, Mr. Chairman. I do know last year out of 440,000 children that were screened under our grant program, there were 28,000 with confirmed high levels and almost 4,000 of those were high enough to require hospitalization and treatment.

Mr. FLOOD. Have you been able to attract other sources of funds any place to help expand this lead poisoning screening program?

Dr. SENCER. We do have the reimbursement mechanism available through SRS in 33 States.

Mr. FLOOD. We would like to know the amount of those resources and the sources.

Dr. SENCER. We will supply that for you.

[The information follows:]

OTHER SOURCES OF FUNDS FOR LEAD POISONING SCREENING

It is reported to us that 275,000 children have been screened and there has been some reimbursement, but there is no record available of what this amounts to.

Department of Commerce title X job opportunities funds for lead poisoning prevention and control that have been made available are Chicago, Ill., $300,000; Massachusetts, $522,200; New York City, $243,600; Newark, N.J., $119,545; Erie County, Pa., $189,780; and New Orleans La., $73,095. It has been brought to our attention recently that some funds are available for lead screening from Housing and Urban Development and Community Services Administration, however; these funds, we understand are directed toward abating lead hazard rather than screening or medical management of the child.

DISEASE INVESTIGATIONS, SURVEILLANCE AND CONTROL

Mr. FLOOD. The budget before us requests $43,411,000 for disease investigation surveillance and control. According to the material that you submitted, the main component of this activity is the Epidemic

Intelligence Service. Give us a little more detail on what this group does. What is this outfit, the number of people and functions, kinds of training they receive and so forth?

Dr. SENCER. The Epidemic Intelligence Service was started back in 1951 when the physician draft was reinstituted at the time of the Korean war. It was recognized at that time there was a need for people trained in epidemiology who could understand how diseases spread and find ways in which to interrupt transmission. This has been a continuous program since then. We recruit physicians to initially serve a 2-year period of time with us. These are people who have finished their medical training, 1 year of internship and usually a year of specialty training. They come in July each year to undergo an intensive 4-week training course in epidemiology and biostatistics. For the remainder of the next 2 years, they work under supervision either in headquarters in Atlanta or assigned to a State health department. When the physician draft ended 3 years ago we were concerned that we might not continue to get the high quality of individuals that we had been attracting, but we still recruit between 40 and 50 physicians for the 2-year period even without the threat of the draft hanging over them.

We are pleased that about 75 percent of the people who have come through this program since its inception—we have had around 770 people come through the program—have continued to work in some form of preventive medicine, either within the Federal Government, in State health departments, or in preventive medicine in the universities.

BIRTH DEFECTS

Mr. FLOOD. Another component of this activity is the birth defects program. Can you tell us how this group is functioning? Give us some examples of their major findings.

Dr. SENCER. This is a collaborative effort with the National Institute of Child Health and Human Development started about 6 years ago working first in metropolitan Atlanta, trying to determine whether it was feasible to get good information at the time of birth on birth defects to see whether there are any clusters of problems that might be related to either some maternal factor or environmental factor.

After determining it was feasible, again in collaboration with the National Institute of Child Health and Human Development, and the National Foundation, this program has been expanded now to receive information on approximately one-third of all births in the country. This is done by utilizing the information in the Commission on Hospitals and Professional Activities, where common discharge summaries on patients from about one-third of the hospitals in the country are maintained on a computer. We have been able to perhaps do more in the way of preventing unnecessary concern over problems than anything else. For example, 2 years ago there was a report out of Australia that a drug that women were taking during pregnancy was causing birth defects. We were immediately able to go to the registry, pull out all of these defects, and do a retrospective study of the mothers and found there was no relationship in a large number of cases. The investigator in Australia withdraw this information.

Recently, from the information, we have been able to alert people that there may be an association between taking valium during pregnancy to minor abnormalities such as cleft palate and harelip.

Mr. FLOOD. What happens to the information developed by these birth defect groups? Do you turn it over to the Cancer Institute or turn it over to NIOSH to see if there is some connection between these environmental factors and birth defects?

Dr. SENCER. We have a quarterly summary surveillance report of the information that comes out of the birth defect monitoring program that goes to a mailing list of around 5,000 people who are concerned with this health problem. At the present time along with the National Institute for Occupational Safety and Health, our Bureau of Epidemiology is investigating a cluster of birth defects in Charleston, W. Va., that again came out of the birth defects surveillance program. The Cancer Institute, of course, gets it, as does the National Institute of Child Health and Human Development and about 5,000 individual investigators.

### OCCUPATIONAL HEALTH INDUSTRYWIDE STUDIES

Mr. FLOOD. In addition to these epidemiology studies conducted by this disease investigation activity, the National Institute for Occupational Safety and Health spends about 90 man-years conducting these industrywide epidemiology studies. How do you tie together these various epidemiology activities? What happens to all the data that is collected?

Dr. SENCER. The data that evolve from industrywide studies are made available in forms of scientific publications, reports to the Department of Labor, back to the industry groups involved, and to the labor unions involved. There is a wide distribution of this information.

Mr. FLOOD. Our concern is that all these potential problems are identified and followed up in a timely way. We want to be assured how your system works.

Dr. SENCER. I think we are all concerned about this. We recently had a training session for many of our epidemiologists in some of the regulations and procedures under the Occupational Safety and Health Act to assure appropriate followup. Also, we are going to put on a concerted effort to clean up all of the backlog in health hazards evaluations that have been accumulated. We have 16, I think it is, of our epidemiology staff who are going to devote the majority of their time over the next 3 months in an attempt to get at this backlog of health hazard requests that NIOSH has received. This is an additional 16 physicians to the staff currently available to NIOSH.

### LABORATORY IMPROVEMENT

Mr. FLOOD. In the budget request you have $15,063,000, an increase of $4,462,000 for the laboratory improvement program. Is that a turnaround? In the last couple years we have been saying much work had to be done in the area, and all we encountered was a lot of resistance. We couldn't put a glove on it. What happened to bring about this change? How do you plan to spend the money?

Dr. SENCER. In two ways: First, under the interagency agreement that I mentioned in the opening statement, we will have an increased responsibility in monitoring laboratories that we currently do not monitor. These include independent laboratories and hospital laboratories that have been covered only by the Joint Commission on Hospital Accreditation.

There will be an increase in our workload, doubling the number of laboratories that we will be montioring each year. There will be an increase in the proficiency testing program sending out check specimens to the laboratories. Second, but more important than that, there will be some seed money to State public health laboratories to help them improve their own program of control of laboratories within their jurisdiction, not their own laboratories but laboratories in the States.

Mr. FLOOD. All right. Of these laboratories inspected during the last year, how many were found to meet the standard?

Dr. SENCER. One of the reasons that there is an increase in the budget this year, Mr. Chairman, is that in the past there have been two standards—one standard for laboratories in interstate commerce and one for those not. The standards are being increased now for the laboratories that have not been under interstate standards. There are approximately 1,400 laboratories in interstate commerce that do meet our standards. We have found that in the inspection process after you point out deficiencies, most of these will be corrected within the next 2 weeks and so the laboratory can go ahead and be accredited. We find very few laboratories that don't want to correct a deficiency once it is found.

## HEALTH EDUCATION

Mr. FLOOD. Last year you told us that the Bureau of Health Education compiled quite a catalog on health education activities supported all through HEW. What have you done since last year? What specifically do you plan for fiscal 1977?

Dr. SENCER. This is the plan on health education which, last Friday, you requested from Dr. Cooper. I have that and will submit it for the record.

Mr. FLOOD. All right.

[The information follows:]

## Health Education

Prevention is a major theme in the Public Health Service's Forward Plan for Health (June 1975). Health education of the public is included as an essential element of a comprehensive approach to prevention and is an integral part of the approach to each preventable health problem discussed in the plan. Health education is a recurring theme throughout the pages of this document.

Conceptually, prevention can be viewed as the collective action of individuals and society which, in its broadest sense, is aimed at freeing the public from preventable disease, injury, and impairment, and providing the opportunity and information needed to maintain a state of good health. Prevention in general -- and health education specifically -- are multifaceted efforts, with a variety of approaches, in a variety of settings, by a variety of actors. The last very emphatically includes the individual himself, for many of the risks the individual faces today he has inflicted on himself.

Health education is an essential element of nearly every Public Health Service program. It is an instrument for prevention and control of disease, an important service to be provided through health care delivery programs, and a key component of consumer protection activities. Health education is a significant part of the programs of numerous Federal agencies outside PHS, both within and outside the Department of Health, Education, and Welfare.

Educational activities related to hypertension, or drug abuse, or venereal disease draw their substance from the control programs of which they are an integral part. By the same token, the educational activities of community health centers, migrant health programs, etc., are interwoven with other services provided.

Therefore, the keystone of the Public Health Service strategy for health education in the Forward Plan is that each Agency and program should retain, and fulfill, its primary responsibility for health education related to its mission.

To divorce this responsibility from the programs through the creation of a separate, superimposed health education bureaucracy would diminish the effectiveness of the PHS and Departmental effort. It would also inevitably lead to widespread duplication of activity, since the Agencies and programs would very appropriately feel compelled to continue some form of educational activity related to their respective goals.

This principle of primary responsibility in the programs should not be interpreted to imply, however, that there is no need for coordinative and facilitating activities across Agency lines. A preliminary survey of PHS and other HEW health education activities indicates very clearly that the health education responsibilities of the various Agencies are being unevenly fulfilled. There is evidence of competition among programs for the attention of common target populations. Still more serious are the gaps in health education services resulting from inattention or low priority accorded to these services.

A strategy for health education is being implemented which will assure:

1. That each Agency and program define more precisely the health education component of its mission, assign adequate resources to it, and be accountable for this component;

2. That a data base on health education activities of the Agencies and programs be established and maintained, and that information be continuously shared among the programs;

3. That existing mechanisms be more full exploited, and new mechanisms be developed, for inter-Agency collaboration on health education problems and activities of mutual importance;

4. That one operating Agency of the PHS be charged with the primary responsibility, serving as a source of technical assistance and consultation to other Agencies and as an agent for innovation in health education methodologies.

Neither a major organizational realignment nor a great new infusion of financial resources is planned to develop and carry out an effective Public Health Service and HEW health education strategy. Instead, concerted effort to make better use of the existing structure and the total substantial resources currently devoted to health education will bring about the desired results.

In developing such a strategy for the Public Health Service and the Department as a whole it was important to recognize that the great majority of health education activity is carried on outside the Federal establishment--in schools, in health care facilities, in official and voluntary agencies at State and community levels, through mass media, and in many other formal and informal settings. Thus, PHS and HEW activities in health education will be responsive to and supportive of these non-Federal endeavors.

Similarly, it was necessary to recognize that health education is a process requiring the knowledge and skills of a very wide range of professions and disciplines. It is not the exclusive province of the health educator or communicator, although they have important roles to play. Physicians, nurses, dentists, and other health professionals; teachers; behavioral and social scientists; a great variety of outreach workers; and private citizens interested in health goals all contribute to the health education process, and all need to be taken into account in considering health education manpower needs and program potentials.

Thus, a successful Public Health Service and HEW strategy for health education will catalyze a truly national, as distinct from a Federal, effort. Each Federal agency needs to work with, and through, its special private sector constituencies -- another compelling argument for vesting primary responsibility in each agency and program. At the same time the coordinating Agency needs to serve effectively as a point of information dissemination and referral for the private as well as the public sector.

The President's 1971 Health Message to Congress stated that "...there is no national instrument, no central force to stimulate and coordinate a comprehensive health education program." The immediate outgrowth of the President's statement on health education was the appointment of the President's Committee on Health Education, which was charged with recommending "ways to develop in the general public a sense of 'health consumer citizenship'." The Committee made two major recommendations: (1) that a National Center for Health Education be established in the private sector "to stimulate, coordinate,

and evaluate health education programs;" and (2) that HEW work with all Federal Agencies to make the most of the Federal Government's involvement in health education.

The Committee's report was presented in September 1973 and the Secretary of HEW was asked to develop an action plan for Federal response to these recommendations. An inter-agency task force proposal, refined and modified by the Office of the Assistant Secretary for Health, was approved by the Secretary of HEW in May 1974. The task force made three major recommendations:

1. Federal support, conditional upon matching funds from the private sector, to initiate an outside-the-Government health education consortium, to be known as the National Center for Health Education.

2. Creation of a Bureau of Health Education within the Center for Disease Control to serve as the Department's operating focus for health education activities.

3. Establishment of an Intra-Departmental Health Education Committee (now established as a Panel), staffed by the Bureau of Health Education, to assure effective coordination of Federal resources devoted to health education purposes.

The Intra-Departmental Panel for Health Education of the Public, an important resource that will facilitate the Bureau's coordinative efforts in the public sector, was established in September 1974 and is chaired by the Assistant Secretary for Health. It's primary responsibility is to advise and make recommendations on health education to the Secretary of HEW. In carrying out this responsibility, it also:

1. Develops and recommends for the Department a set of policies related to health education of the public.

2. Recommends that appropriate attention be given to health education within each Agency's programs.

3. Identifies educational goals common to two or more Agencies and develops and recommends methods for interagency cooperation in accomplishing these purposes.

4. Recommends appropriate consideration of health education in the implementation of major Departmental initiatives.

5. Conducts liaison activities with other Federal departments and agencies and with the private sector in relation to health education programs.

Panel membership includes: Assistant Secretary for Education; Administrator, Alcohol, Drug Abuse, and Mental Health Administration; Director, Center for Disease Control; Commissioner, Food and Drug Administration; Administrator, Health Resources Administration; Administrator, Health Services Administration; Director, National Institutes of Health; a Regional Health Administrator; Commissioner, Medical Services Administration (SRS); and Director, Bureau of Health Insurance (SSA).

Liaison Panel members include designated representatives from the Office of the Secretary of HEW: Office of Child Development; Office of the Assistant Secretary for Planning and Evaluation; and Office of the Assistant Secretary for Public Affairs.

A panel liaison group, composed of key staff members appointed by the Agency heads, constitutes a work force to facilitate interagency action, and to assure exchange of information among Agencies. Members of this group are the initial points of contact for the Bureau of Health Education in its work with the respective Agencies.

The Bureau of Health Education was officially established in the Center for Disease Control in September 1974. The Bureau is charged with the following responsibilities:

1. Serving as the Federal agency with primary concern for promoting the appropriate implementation of health education. As the lead agency in the development of objectives and priorities for health education activities within HEW, provides guidance to other public and private sector organizations.

2. Providing consultation and technical assistance. Serves as a professional resource and referral center for health education and smoking information in both governmental and private sectors.

3. Providing direct program services. Develops and evaluates demonstration health education programs and methodologies designed to reach specific target groups.

4. Providing research and evaluation servies in smoking programs. Provides leadership and direction for a national program to reduce death and disability due to cigarette smoking.

In response to the recommendation that a non-governmental focus was needed, CDC established a contract with the National Health Council to conduct a study of a private-sector-based National Center for Health Education.

The final contract report, delivered in early FY 1976, provided guidelines for future Bureau and Panel recommendations with regard to the Federal Government's cooperative relationships in health education with the private sector. The National Center for Health Education was established with private funds, and the Board of Directors had their first meeting in October 1975.

In summary, the PHS long-range strategy for health education policy and action is based on the principle that each Federal Agency and Program retains ultimate responsibility for the health education activities essential to the fulfillment of its mission.

The programs of the Bureau of Health Education should in no way be viewed as the total Public Health Service investment in or commitment to health education. The Bureau's resources actually represent a relatively small proportion of the resources dedicated to health education of the public by the PHS as a whole, as is evident in the PHS Forward Plan. PHS resources in turn represent only a part of the total actual and potential Federal commitment to health education of the public, which is shared by other Agencies within HEW and by other Federal Departments and Agencies.

The principal role of the Bureau of Health Education is to encourage, support and assist other Agencies in carrying out their appropriate health education functions, to supplement and strengthen--not supplant--programs of other Agencies and to provide vigorous over-all leadership to health education efforts.

The attached report on Health Education Activities summarizes progress attained thus far under the plan approved by the Secretary in May 1974.

HEALTH EDUCATION ACTIVITIES, FEBRUARY 1976

The Center for Disease Control (CDC) is charged with providing leadership and direction of a national health education program, the ultimate objective of which is to equip and encourage individuals, families, and community leaders to make decisions and take actions that will protect their health, make more effective use of health services, and thereby prevent unnecessary morbidity and mortality caused by a lack of health knowledge.

This mission presupposes that the requisite health knowledge exists, and that communication channels and educational methods exist or can be developed. Fulfillment of this mission involves working with and through health professionals, educators, and others now charged with education responsibilities in health and disease prevention programs, and with and through educational channels and resources already in operation in the Department of Health, Education, and Welfare, other Federal agencies, State and local agencies, and organizations in the private sector. Closely related to this general mission, the Center has specific responsibility for carrying out the programs of the National Clearinghouse for Smoking and Health (NCSH). These programs include educational activities, which are integrated with the general health education mission of the Center while retaining antismoking emphasis, plus scientific and technical services related to the health consequences of smoking. The Center provides leadership and direction in programmatic health education activities by:

(1) Serving as the Federal agency with primary concern for promoting the appropriate implementation of health education. As the lead agency in the development of objectives and priorities for health education activities within DHEW, provides guidance to other public and private sector organizations.

(2) Providing consultation and technical assistance. Serves as a professional resource and referral center for health education and smoking in both governmental and private sectors.

(3) Providing direct program services. Develops and evaluates demonstration health education programs and methodologies designed to reach specific target groups.

(4) Providing research and evaluation services in smoking programs. Provides leadership and direction for a national program to reduce death and disability due to cigarette smoking.

*The Bureau of Health Education*

The action plan developed by the Center and signed by the Secretary in May 1974 called for the establishment of a Bureau of Health Education at CDC as the Federal focus for activities relating to health education of the public. Several important actions have been taken to implement this initiative.

*The intradepartmental panel for health education of the public*

A significant accomplishment in recognizing the importance of health education has been the establishment of the intradepartmental panel for health education of the public. 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 officers from the Office of the Secretary. The panel is designed to provide a forum for discussion and a mechanism for recommending departmentwide health education policies and priorities at the highest level, and for encouraging departmentwide and interagency health education efforts directed toward the solution of health and disease prevention problems common to several agencies. A liaison group, composed of key staff members designated by the agency heads, constitutes a working force to facilitate and implement interagency action, and to assure interchange of information among agencies. Members of this group are the initial point of contact for the Center in its work with the respective agencies.

The panel has initiated interagency task forces to develop departmentwide policies and strategies for the high priority health program areas of: 1. target populations; 2. research and evaluation; and 3. reimbursement and insurance. The task forces are currently developing recommendations for specific program activities which the Department should implement. The recommendations will be presented for consideration by the panel at the March 1976 meeting.

*Review of HEW health education activities*

A primary function of the Center for Disease Control is to develop and recommend to the Department guidelines and standards for health education programs.

As a first step, an indepth review has been initiated to determine: what health and disease prevention problems are addressed by Department programs; what health education approaches are being used and what the actual accomplishments are; and what population groups are being reached. The review will produce a data base which will be made available to other agencies within the Department and to nongovernmental interests which ask for assistance.

Data has already been collected from all departmental agencies on the legislative mandates under which they perform health education activities. Information to date gives some idea as to the magnitude of this undertaking. The review of the Health Resources Administration, now essentially complete, identifies approximately 400 health education projects or activities. Other agencies and offices give evidence of major health education activities as an integral part of broader-based delivery programs.

*Federal agency activities*

For the most part, satisfactory coordination and integration of the various health education activities among Federal agencies, both inside and outside the Department, has not been accomplished. Efforts are being made to assure that health education is included as part of programs where it would be appropriate and productive. Efforts are also being made to coordinate efforts where they should be coordinated. The Center has acted to stimulate and participate in interagency health education activities. Through interagency reimbursable agreements, National Cancer Institute and Office of Education funds are supporting a number of demonstration and/or evaluation projects in health education. In DHEW region I, Center staff has participated in a workshop for Regional Office personnel representing all PHS programs to highlight health education as it affects each program's responsibilities. The Center is collaborating with the region V Office to hold a conference on health education. Assistance is being provided region IV in the review of project proposals for health services and prevention programs to assure the appropriateness of health education content. In region III the Center is collaborating with the FDA and the regional office in a bicentennial exhibit on smoking. Meetings have been held with the other regional health administrators and key staff to discuss new health education initiatives and identify common goals. The Center supports a health education demonstration project with the Department of Agriculture/University of Arkansas Cooperative Extension Service which is designed to demonstrate the effectiveness of extension programs in reaching rural populations in need of disease prevention and health education services.

*State and local government activities*

The Center recognizes liaison with appropriate non-Federal personnel to be an important responsibility in achieving health education and promotion objectives. Consequently, personnel of non-Federal agencies have been invited to participate in various health education activities by the Center. A national conference was held at CDC in June 1974 at which 150 representatives of State and local governments, professional, and voluntary agencies, and other Federal agencies, including all HEW regional offices, participated and recommended priorities for the then proposed Bureau of Health Education. The input of such a group was considered of importance in launching more intensive Federal efforts in health education and promotion.

The Center has been involved in the development of health education guidelines as part of implementation of the National Health Planning and Research Development Act of 1974 (Public Law 93-641). In addition, the Center has been instrumental in the appropriate involvement of State and territorial directors of Public Health Education in planning these guidelines.

Attempts to establish liaison with and become known by official State health agencies is beginning to have beneficial results. Assistance has been provided to Tennessee and New Jersey in the design of new health education programs. Florida, Tennessee, and New Jersey have requested such assistance. Virginia has asked for help in evaluating ongoing programs. Ohio, Maine, and several other States have expressed interest in various health education projects, and discussions are underway to implement broadly based mass media smoking and health education programs.

The Center has participated in planning and provided partial support for a 6-State conference (DHEW region I) to be held later this year on cancer education. Participants will represent State health, welfare, and education agencies, voluntary agencies, and universities.

*Establishment of the National Center for Health Education*

At the recommendation of the President's Committee on Health Education in 1971, a contract was established with the National Health Council to explore the feasibility and recommend the functions, structure, and organizational nature of a private-sector based Center for Health Education. The outcome of the study was the establishment of the National Center on October 1, 1975 (see attached NCHE design proposal). This was a noteworthy and major step forward for health education and promotion. The Board of Directors is broadly representative of the major private interests in health education.

CDC has begun work with the National Center in selected program areas of mutual concern to the private sector and to the Federal Government which are best managed in the private sector. These activities currently include developmental studies in the areas of health education manpower, patient education programs, and health education as related to health planning.

*National Interagency Council on Smoking and Health Activities*

The Center, through the National Clearinghouse for Smoking and Health, is an active member of the 32-agency National Interagency Council on Smoking and Health (NICSH) providing primary representation for Federal agencies. Most of the members are voluntary and professional organizations. The Council receives its principal support from the American Cancer Society, with smaller financial contributions from other agencies. The NICSH plays a major role in antismoking health education. It sponsors Antismoking Week each year and provides a forum for Interagency Councils.

*International activities*

The Center provided assistance in planning the conference and program segments of the 3d World Conference on Smoking and Health which was held June 2–5, 1975, in New York City. The World Conference is the major international assembly to pool new scientific data and discuss programs and problems. This third Conference brought together more than 500 physicians, scientists, and educators on an invitational basis. Center staff prepared position papers and provided technical information to the organizing committee and scientists making presentations.

The Center represents the U.S. Public Health Service on the Technical Development Board of the International Union for Health Education (IUHE). Current work with the IUHE is in the development and promotion of an international conference on health education in Ottawa, Canada, in August 1976. The purpose of this conference is to provide a forum for sharing knowledge and experience in health education methods and approaches to health and disease prevention problems which may be of benefit to the health programs of other nations.

*Consultation and technical assistance*

During fiscal year 1975, the Center provided consultation and technical assistance to a wide variety of individuals and organizations in order to assist them in planning for and/or implementing some action in an area of health education which was of concern to them or their organizations. An important function of the Center during its first year was to establish its identity and credibility with these groups which include medical and health professionals; and Federal, State, local, and international health and educational agencies.

Specific assistance in the field of smoking has included:

The processing of 14,000 letter responses to public inquiries;

Responses to 2,100 telephone inquiries on smoking and health;

The processing of 3,600 requests for technical literature and 700 requests for searches of literature in computer storage;

The distribution of 6,000 copies of the Directory of Ongoing Research and 3,900 copies of Smoking and Health Bibliography;

The preparation and distribution of the 1975 Health Consequences of Smoking Annual Report to the Congress; and

The development of a desk reference on smoking and health for use by the health, scientific, and educational communities.

The desk reference, consisting of a summary volume of the most important chapters of previous smoking annual reports and a bibliography, and appropriate legislative recommendations, will replace the current format of the annual report to Congress.

DIRECT PROGRAM SERVICES

The Center provides direct support to a variety of health education activities aimed at its ultimate objective of educating people to make wise decisions about their health. These projects are discussed below under five general areas: 1. school related, 2. special target population groups, 3. patient education, 4. conferences, and 5. smoking behavior research.

1. *School related*

While conduct of good health education programs to prepare youth for contemporary living has long been a stated goal of health and education authorities, attempts to establish and improve preventive health education in the first 12 years of formal schooling have been largely ineffective. Youth leaving school are generally not well prepared to protect and promote their health or their families or their communities. To bring about a change in this situation, the School Health Curriculum Program was developed and initiated. It is a combination health education curriculum, school staff training, and community health resource development endeavor. About 175 school districts and their community agencies are now involved, and assistance is provided to those wishing to introduce the program.

The curriculum is based on a highly developed series of learning experiences, activities and resources to help develop understanding and appreciation of the body, what can be done to protect it, and how decisions and the environment have impact on it. Units of work, running about 12 weeks per year, focus on priority health matters and cover a very broad spectrum of health issues. The fourth grade unit deals with energy, nutrition, and the digestive system; the fifth grade unit deals with the lungs and respiratory system; the sixth grade unit deals with the heart and the seventh grade unit with the brain. A third grade unit on vision, eyes, and the senses will be introduced during the 1976–77 school year. Units for kindergarten and grades 1 and 2 are being planned.

Two weeks intensive training and close followup monitoring is provided to teams of educators from one school who then spread the training to others. Community agencies supply much of the help, including funds to help launch and continue the work as a total local responsibility.

Several contracts are in effect to develop, evaluate, and update curriculum classroom methods, and teacher training techniques.

2. *Special target population groups*

Frequently certain identifiable groups suffer disproportionately higher rates of morbidity and mortality from many diseases than other groups in our society. They often do not have ready access to health services or knowledge of how to utilize them. Moreover, "conventional" health education materials and approaches are frequently not appropriate due to cultural, ethnic, or socioeconomic considerations. A number of developmental and demonstration projects are in progress to develop and evaluate innovative methodologies to reach these groups.

A major project now being carried out by the Center is through a contract with the University of Arkansas Cooperative Extension Service to test and demonstrate the potential of this existing outreach system as a delivery system for disease prevention and health education services. The system has proven effective in reaching rural population groups.

The program is designed to utilize the standard extension service approach to community development and group process to determine how effective this delivery system can be in changing health attitudes and hopefully health behavior of rural populations. Although the project is statewide in scope, it concentrates efforts in 15 selected counties which are working on specific educational projects directly under the county agricultural agent and home economist. The professional health education staff of the project provides advice and guidance and professional subject matter assistance to the county staffs.

In two counties, these staffs are working with 4H and other youth to modify behavior of the local farmers in the use of pesticides and the disposal of the residue and containers. In two others, they are planning work-study programs designed to teach youth about the health care system in the local area. They will then utilize these youth as resource workers to spread this information throughout the communities. In still other counties, indigenous health education aides have been assigned to work with selected families in their com-

munities over a 6-month period of time. Other projects are in hypertension education and health decisionmaking.

Each county has a planning committee composed of local lay people and professionals. These committees provide active program planning and guidance to the community by bringing together interested organizations and health providers as resources to community-based activity around the catalyst—the county agent or home economist.

A second special target group project now in effect is in cooperation with the Tuskegee Area Health Education Center, Inc. (TAHEC). An important need in the delivery of health education, especially in rural areas, is the coordination of the information and services being provided by the many different agencies involved. The center is working via contract with a consortium of health and education agencies in the Tuskegee area to find ways of improving the cooperation and communication of health education delivery systems in poor rural areas. An initial step has been a health and disease prevention problem analysis of each consortium group's area, identifying the existing health education services being provided locally by public and private groups, and the gaps that exist in this delivery system. From this diagnosis, efforts to bridge identified gaps by cooperative efforts will be developed. It is hoped that by identifying ways of promoting cooperation in the Tuskegee area, community action models will be documented that will work for other rural areas with similar populations.

A third project is being accomplished in association with the New Mexico Health Education Coalition. One of the major problems facing health education is reaching populations with widely varying social, education, and ethnic backgrounds. The different medical needs, perceptions, and information levels of these "target populations." The New Mexico coalition is in an excellent position to work with a number of such target populations as well as the health and education agencies attempting to meet their needs.

Health education models are being developed for three selected populations—rural, barrio, and Indian—in New Mexico. This activity, involving identification and development of indigenous community leaders and organizations, is actually defining and initiating programs to meet local health education needs. Specific health problems have already been identified in each community and the indigenous workers are working with the local populations and their leaders. The next step will involve the training and marshalling of resources to help them meet the local needs within the realities of each situation. The school health curriculum project has been introduced and is being expanded as an integral part of the coalition's work.

A fourth and potentially very important project is an attempt to increase the supply of kidneys available for transplant. Until quite recently, end-stage renal disease (ESRD) was a condition which invariably resulted in death. The technological development of dialysis (the kidney machine) and kidney transplantation have provided ESRD patients with a viable mode of managing this catastrophic health problem. There are two ways to provide effective support to ESRD patients, i.e., having more patients on home rather than institutional dialysis, and transplanting more kidneys rather than dialyzing more patients. Performing additional transplants is more advantageous, because a patient with a successful transplant has an almost normal quality of life. Unfortunately, the prospect for doing many more transplants is poor, because there is a severe shortage of the availability of transplantable kidneys.

The center has undertaken pilot projects with end-stage renal disease (ESRD) institutions in Seattle, Kansas City, and Atlanta to increase the supply of cadaveric kidneys for transplantation. The programs supported by the Center will develop surveillance procedures which will identify potential donors as they come to medical attention. In addition, a health education outreach effort will be developed to inform persons of the need for kidneys and of the procedures for donating kidneys. During the next 18 months to 2 years these programs will develop operational procedures and health education methods which can be used to increase the supply of transplantable kidneys. These projects will be documented as demonstration projects and, if successful, their approaches will be adapted for introduction in other areas of the country.

A number of additional projects are currently being carried out under contract with various local and national groups to develop prototype education/prevention programs for special target groups.

*3. Patient education*

Patients receiving health and medical services in hospitals and health care delivery organizations need and are receptive to health education programs. Activities are underway to assist health professionals in the development and delivery of model patient education programs. Patient education represents a vital and rapidly growing segment of the total preventive health education delivered today. In beginning to look at this complex area, the center has identified the hospital setting as one which has great potential for improving and coordinating the delivery of patient education by the entire health care system.

The American Hospital Association continually collects and updates information on U.S. hospitals, and the center is working with them to analyze their information in the area of patient education. From this analysis, the center will be able to get a more accurate, comprehensive picture of the current level of resources and programs in hospital based patient education programs. Future studies will determine those factors that characterize successful programs and ways in which the center can more effectively raise the overall level of patient education being delivered throughout the country.

This project is also intended to increase the communication between those working in the field by identifying people and places concerned with similar problems and by identifying existing programs which can provide local experience and assistance to those who are trying to develop new programs.

Another activity is being carried out in conjunction with the American College of Radiology to develop, test, and disseminate health and cancer education programs for the use of health professionals working in medical care facilities.

The Center has collaborated with DHEW Regional Offices and other agencies in supporting several regionwide conferences on improving health education programs. In addition to those discussed already, activity is underway with the New Hampshire School of Health Studies to stimulate health education activity in the New England States; with the Colorado Regional Cancer Center to convene regionwide conferences on improving health education programs dealing with the prevention and control of cancer; and with the University of Illinois School of Public Health to convene a regionwide conference on improving health education programs dealing with the prevention and control of cancer.

*5. Smoking behavior research*

A primary basis of the National Clearinghouse for Smoking and Health and the strength of its relationship with other governmental agencies and the private sector has been its ongoing research program concerning public attitudes and behavior regarding cigarette smoking. Because cigarette smoking has been so ubiquitously socially acceptable that is, guilt or shame are not commonly associated with smoking, much valuable information has been acquired from the baseline data that has much broader public health application than cigarette smoking. These data have provided, and continue to provide, a basis for community-wide health education programs, not only in smoking but in other health program areas.

A current project of particular interest provides data on adult attitudes and behavior about cigarette smoking, and another provides data on attitudes and behavior of physicians, nurses, dentists, and pharmacists regarding cigarette smoking and diseases associated with smoking.

SUMMARY

The preceding report is evidence that better coordination of Federal efforts and more apropriate inclusion of health education activities in productive areas have begun. The job to be done is a massive one, but the structure has been established, and efforts are being made in the right direction.

INTERAGENCY COLLABORATION

Dr. SENCER. As I mentioned, I think the two encouraging things are the interagency collaboration in the end-stage renal disease program and the National Center for Health Education which I should have mentioned earlier as part of the health education program. The

Clearinghouse on Smoking and Health also is supported out of this activity. We are looking at a variety of ways in which we can supplement the educational activities that have gone on in alerting people to the hazards of smoking, such as in trying to find better ways of minimizing the amount of tar and nicotine to which people are exposed.

Mr. FLOOD. What impact, if any, have you had to date on combining efforts in the health education activities funded all through HEW?

Dr. SENCER. I am not sure that our small appropriation has made any real impact, but we do have people now utilizing techniques that others have developed. Instead of three different agencies aiming their educational programs at the same target population, we have identified certain target populations in which we will concentrate our health information and education efforts. We have been able to get together the people in the regional offices who are working on health education programs, and I think, if nothing else, we have people talking to each other, which is the first step in getting any cooperation.

Mr. FLOOD. How much support do you receive from all these HEW programs to operate the health education program?

Dr. SENCER. We are getting considerable support from the National Cancer Institute to help in some of our health education programs that put a high priority on cancer. We also get support from the Office of Education in developing school health education curriculums and programs.

### NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

Mr. FLOOD. For the National Institute for Occupational Safety and Health, you propose to eliminate training grant programs. We are under the impression there is a pretty severe shortage of manpower in this area. Do you have any evidence to show us that we have sufficient qualified manpower in this area?

Dr. SENCER. We agree with you that there is insufficient manpower, but we feel there are other ways in which the training activities that are currently supported by NIOSH could be funded. Many of these are in community colleges, in undergraduate institutions, and we feel that there are other funds for education that should be used for this purpose.

### OCCUPATIONAL SAFETY AND HEALTH MANPOWER NEEDS

Mr. FLOOD. Have you done any studies to determine the number of researchers, epidemiologists, industrial hygienists, and other health and safety professionals needed at the present time? Also, how many are we going to need, say, in the next 10 years?

Dr. SENCER. Do you have the figures, Dr. Finklea?

Dr. FINKLEA. Mr. Chairman, we have done such studies, and we do anticipate a greatly increased demand for people with specialty training: About 1,000 certified occupational health physicians, about 20,000 physicians with short-term training in occupational health, about 4,000 industrial hygienists, 4,700 safety professionals, and about 25,000 nurses. These are the deficits we have.

Mr. FLOOD. We are trying to point out the importance of this baseline information. Obviously, this kind of information is going to be very necessary if you are going to have any successful occupational

safety and health program of any kind. This is baseline information. What about it; do you have it?

Dr. FINKLEA. Yes, sir, we do have a summary.

TRAINING GRANTS

Mr. FLOOD. The NIOSH justification that you sent up with the material indicates you plan to support 50 training grants in 1976. What kind of manpower are you training? How many people are going to emerge from these programs?

Dr. FINKLEA. I have the information on that, sir.

Mr. FLOOD. All right.

Dr. FINKLEA. On the training grants as of this current fiscal year—let me differentiate between supported students and students who are studying in supported programs. We have a total of 35 physicians who will be working in supported programs of whom the Institute itself will support 10. There are about 175 specialists in occupational health nursing who will be trained in the programs we support. We are supporting 25 of these students. We have 160 people that will be trained in industrial hygiene in programs supported by the Institute this year, of whom we will support 6 '.

In safety management and engineering, in terms of professional-level training we will be training about 50 people, of which about 25 students will be receiving direct support. In occupational safety and health technicians, in demonstration programs, we will be supporting 275 students, 25 of whom will receive assistance from the program. In terms of safety and health biostatisticians or epidemiologists, 10 people supported, of whom 5 will receive direct support.

Mr. FLOOD. How did you decide which of these kinds of manpower to train?

Dr. FINKLEA. I think this is the spectrum of manpower that is required.

TOXIC SUBSTANCES

Mr. FLOOD. Take a look at page 138 of your justifications. You state there—let me quote your language. This is what you say you are going to do: "Define chemical or industrial processes which manufacture or use suspected carcinogens." How do you do this? How many have you defined in the past year?

Dr. FINKLEA. We do this by several mechanisms, sir, by subset of material from the Toxic Substance List. There are 1500 suspect carcinogens we are working with.

Mr. FLOOD. Suspected carcinogens?

Dr. FINKLEA. Yes, sir, these are chemicals that have contributed to cancer in one or more animal studies or in human studies. We also do this with the National Occupational Hazards Survey. This survey tried to ascertain what exposures American workers might be encountering. We anticipate that survey being completed this September.

Mr. FLOOD. After you define a process that is expected of causing cancer, what is the next step?

Dr. FINKLEA. We have really 2 sets of agents we are concerned about. One would be approximately 1500 agents which we suspect may

be carcinogens. The other would be a subset of about 50 agents which the International Agency for Research on Cancer has designated to be most suspect. We have requested information from industry in preparation to giving recommendations for standards to the Department of Labor. Unfortunately our response from industry has not been as vigorous as we hoped it would be. We have not received a lot of useful information. We will be proceeding to give recommendations on work practices and controls to the Department of Labor on those agents.

Mr. FLOOD. How successful have you been in the whole effort?

Dr. FINKLEA. I think this part of the effort is just beginning. There was a standard issued on 14 carcinogens by the Department of Labor. There have been some difficulties with legal challenges to the Department of Labor on these standards.

CARCINOGENESIS PROGRAM

Mr. FLOOD. Last year we provided $4,852,00 and 100 positions to expand the NIOSH occupational programs on carcinogenesis. Did you use this additional money, these funds?

Dr. FINKLEA. These funds are just becoming available now with the appropriation.

Mr. FLOOD. Are you speaking of the carcinogenesis program now?

Dr. FINKLEA. Yes, sir, that is right.

COORDINATION WITH NATIONAL CANCER INSTITUTE

Mr. FLOOD. In the report to last year's appropriation bill we directed the National Cancer Institute to work with NIOSH on occupational carcinogenesis. How is that working out and what have the two organizations accomplished up to date?

Dr. FINKLEA. Dr. Rauscher, as you recall, is head of the National Cancer program and CDC is one of the participating agencies. We have met with Dr. Rauscher and his staff to assure that, with the passage of this fiscal year 1976 appropriation, this cooperation with his staff would be continued and enhanced. Our staffs review information from the biotest program of the National Cancer Institute. We are alerted by the Institute to substances that may pose hazards to workers. When we receive new information on such chemicals, we issue current intelligence bulletins providing background information such as, its known toxicity to man and animals, known producers and users, estimated extent of occupational exposure, and further action, planned by NIOSH.

Mr. FLOOD. I tell you what you do. You amplify this at some length for the record.

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

[The information follows:]

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

The National Institute for Occupational Safety and Health has and will continue to depend heavily on National Cancer Institute to conduct research on the basic causation of cancer; to carry out animal studies to test chemical agents for possible human carcinogenicity; and to conduct research on the early diagnosis and treatment of environmentally induced cancer. National Institute for Occu-

pational Safety and Health will concentrate its efforts on (1) the study of cancer incidence among working populations through hazard evaluations and field studies; (2) alerting the occupational health community to potential cancer risks in the workplace; (3) developing effective environmental control technologies to minimize exposure risks; and (4) assuring to the extent feasible, that our recommended standards to the Occupational Safety and Health Act will protect the worker from any increased risk to cancer. When taken as a whole, this represents a coordinated approach to the occupational cancer problem and takes advantage of the strengths of our respective staff capabilities and legislative authorities.

To illustrate how this cooperative approach will, and is in large part now working, National Institute for Occupational Safety and Health will have input into the development of priorities for the National Cancer Institute bioassay program. Our recommendations will be based upon, among other factors, information obtained from our field studies and surveillance systems on possible incurred cancer risks among worker populations exposed to certain chemical agents. We will also serve on the National Cancer Institute's Committee which evaluates the results of the bioassay program. Once a chemical is found to be carcinogenic in animals, we determine the working population at potential risk and issue an appropriate alert to the occupational health community, management, and labor. The information on cancer will be used to update and recommend changes in current health standards, as indicated. Also, the bioassay findings will be used in developing priorities for future field studies and criteria development programs.

Other areas where our staffs work closely together includes programs on cancer information and prevention programs as these relate to occupational cancer; studying the risk of pregnant women and their offspring to cancer producing agents found in the workplace; and use of National Cancer Institute data on the geographic incidence of cancer to identify area where occupation may be a related factor.

National Institute for Occupational Safety and Health is pleased with the cooperation we have been getting from the National Cancer Institute in the past and can assure that our respective staffs have been in frequent communications at various levels. We believe our programs are by and large well coordinated and mutually supportive.

CRITERIA DOCUMENTS

Mr. FLOOD. You state in your justification you plan to complete in 1976, 24 criteria for occupational safety and health standards. Is that still a good figure?

Dr. FINKLEA. Yes, sir, that is correct.

Mr. FLOOD. Is there slippage?

Dr. FINKLEA. We had slippage last year.

Mr. FLOOD. Then for the record list the criteria you plan to complete in 1976.

Dr. FINKLEA. Be happy to.

[The information follows:]

CRITERIA DOCUMENTS PLANNED FOR COMPLETION IN FISCAL YEAR 1976

Acetylene
Allyl chloride
Anesthetic gases
Anilines
Boron trifluoride
Carbaryl
Carbon tetrachloride
Chlorine
Dioxane
Ethylene dichloride
Formaldehyde
Hydrogen fluoride
Isopropyl alcohol
Logging (felling to first haul)
Malathion
Methyl alcohol
Methylene chloride
Methyl parathion
Nitric acid
Oxides of nitrogen (nitric oxide and nitrogen dioxide)
Parathion
Phenol
Phosgene
Tetrachloroethylene (perchloroethylene)

Mr. FLOOD. How many criteria documents do you plan to complete in 1977?

Dr. FINKLEA. The initiative last year passed by Congress would enable us to do 26 documents. In 1977 we would like to continue at the rate of 24 documents per year. Beginning in late 1977 and 1978 we would like our documents to address more than one occupational hazard. Hopefully with the 24 documents we might transmit a recommendation for the control of somewhere between 40 and 60 agents. This would approach the goal that Secretary Richardson had given the committee some years ago.

VACANCIES

Mr. FLOOD. How many of those 773 jobs authorized for NIOSH are currently vacant?

Dr. FINKLEA. I can give you detailed information on that.

Dr. SENCER. 118 vacancies.

Mr. FLOOD. What are you doing to fill the vacancies?

Dr. FINKLEA. We have had a very vigorous recruiting program under which the Center for Disease Control has provided recruiting specialists for NIOSH. We have simplified and expedited some of the last 60 to 90 days.

INFLUENZA

Mr. FLOOD. By the way, you touched on it briefly but we noticed that brief article in the Wall Street Journal last week, I guess, about this new form of influenza. Is it more serious than the ones that are pretty widespread throughout the country? It hit a few soldiers up at Fort Dix. Can you elaborate on that a little bit?

Dr. SENCER. Yes, sir, I will be glad to comment.

Mr. FLOOD. Supposedly, of course, it is similar to the one that killed millions of people all over the world in 1918–19.

Mr. MICHEL. Was that report right this morning? I think it said 18 million people died during the epidemic.

Dr. SENCER. Yes; that is right.

In late January, Fort Dix experienced an outbreak of influenza-like illness and the New Jersey State Health Department collaborated in getting cultures from the people who were ill. The health department laboratory was able to identify some of these cultures as the virus that is currently causing a good bit of influenza in the United States. We call it the Victoria strain, a virus that came out of Victoria, Australia. But there were several strains that they could not identify and these were sent to our laboratories where we did identify them as being identical with the virus that causes influenza in swine.

This virus is similar to the virus that caused the major pandemic in 1918–19. Viruses of influenza, as you know, do have a tendency to shift their structure around so that they can attack groups of people who have not had that particular strain. We are currently in the midst of intensive investigation of several different population groups to determine whether there is any more of this going on in the country. We want to determine whether this is an isolated incident or whether it may be the beginning of a new strain of influenza that would circulate widely in susceptible populations.

We have met with the vaccine producers to alert them. If it is determined that this is going to be a major new influenza strain, the manufacturers are alerted, they have the virus and are beginning to work with it.

Mr. FLOOD. Can we expect an epidemic of this particular type of influenza next winter?

Dr. SENCER. I think it is too early to speculate. We are concerned, and hopefully within the next 2 weeks we will be able to make a prediction of what the future holds.

Mr. FLOOD. What should we do to get ready for this epidemic?

Dr. SENCER. If we were to believe there would be a major influenza epidemic, we would have to get into major vaccine production. If this virus has not been around since 1918 most of our population will be susceptible to it. If it is circulating in the population, we would probably encourage a major vaccine production effort and, in the fall, a major immunization program.

### INDOCHINESE REFUGEES

Mr. FLOOD. There is considerable question throughout the country about the introduction of some diseases into the country as a result of the Indochinese refugee migration, for instance tuberculosis. Have there been any other problems at all?

Dr. SENCER. No, sir. We have examined the refugees for Hanson's disease, for intestinal parasites, as well as more common conditions. We found very low incidence, and most of them are already under treatment.

Actually, sometimes our society has been a threat to the refugees. We found that they have a custom in Vietnam of eating a dish on their New Year's that is made of raw pork. In Vietnam they don't have trichinosis because there is no meat garbage to feed back to the pigs. Therefore, we sent out an alert that they should not eat raw pork in this country because we do have trichinosis here. We are almost as much a danger to them as they are to us.

Mr. FLOOD. Do you have the TB problem under control?

Dr. SENCER. Yes, it is really a very minor one. In the early days of trying to move the refugees out of camp, some people did not get screened, but after the first 3 weeks of the movement everybody was being screened. Certainly an occasional case will pop up that was missed but it is not a major health problem.

### LABORATORY IMPROVEMENT

Mr. FLOOD. Mr. Michel.

Mr. MICHEL. Thank you, Mr. Chairman. The chairman made mention of that increase that you have in the budget for laboratories of $5 million. Reference is made in your statement to an agreement you had reached with the Social Security Administration and Health Services Administration for better coordination in the monitoring of laboratories. To what extent have some of these laboratories simply sprung up around the country because of all this money that is floating around in the medicaid and medicare programs?

Dr. SENCER. We don't have any estimates. What information we have is anecdotal. Recent publicity has highlighted it. This is going

on. We think, though, that laboratories that are involved in intrastate commerce or in the medicare system are providing good service.

Mr. MICHEL. You mentioned these 1,400 labs in interstate commerce that have quality control standards. Do you have any figures at all on those operating intrastate?

Dr. SENCER. We do know there are about 7,000 laboratories that are independent laboratories, nonhospital-based laboratories that are functioning in interstate commerce. The quality control standards for those laboratories have not been as high as they have been for interstate laboratories. This situation is in the process of being corrected. Medicare is adopting the standards for quality control and proficiency testing that we have had for interstate laboratories, and the personnel standards are also going to be identical. We think with these changes along with other operating changes, such as allowing medicare to do the actual certification while CDC does onsite monitoring, we will be able to maintain higher standards.

LABORATORY LICENSURE

Mr. MICHEL. Do all the States require licensing of laboratories in their States?

Dr. SENCER. No, sir, but with the widespread influence of medicare we feel that just about all laboratories except—I think our figures were about 400 laboratories that were not caught either in the interstate or medicare net.

In addition, there is another rather large segment of laboratory services, not covered. I am referring to laboratory services provided in the physicians' offices. Neither medicare nor the interstate laboratory program gets at the individual physicians' office laboratory.

Mr. MICHEL. Of course, you made mention of all this notoriety that has come to the public attention as a result of the disclosure, particularly in my home State, in Chicago, of these fly-by-night laboratories and the kickback arrangements with some operators. Do you have the resources to beef up surveillance in an area like that?

Dr. SENCER. I don't think we have the resources, and I don't think we have the authority to get involved in that side of it. It is SSA and SRS that are involved in the fiscal affairs.

Mr. MICHEL. But none of those programs is going to be improved unless you have stronger enforcement within a State, isn't that right?

Dr. SENCER. As I said, much of the increased funds would be going to State programs to improve them.

Mr. MICHEL. I noticed that in your earlier testimony the question arose, "What do they know they don't know now?" Dosen't it simply boil down to clamping down and enforcing the law?

Dr. SENCER. Part of it is improving the quality of their inspectors; getting better people who will be more cognizant of the decisions that must be made as they go through the laboratories. We would anticipate that one of the first activities is going to be in the training of inspectors.

In the interstate program we have found that the single activity that is most effective in improving services is the onsite inspection. Improvement comes from being able to not just inspect, but to recognize a deficiency and get it corrected while you are there or shortly thereafter.

OCCUPATIONAL HEALTH RESEARCH

Mr. MICHEL. In the field of occupational health, I know that NIOSH undertakes considerable research in occupational carcinogenesis, but how does their research program differ from that of the National Cancer Institute or National Institute of Environmental Health?

Dr. SENCER. I think NIOSH is in the unique situation to be the first alerted to a problem because they are dealing with population groups that are under heavy exposure in a variety of things. This brings to light problems that can then be tracked down in a more basic manner.

Dr. Finklea, would you like to comment?

Dr. FINKLEA. I certainly concur with that. I think that NIOSH can look at the experience of workers who have been exposed to groups of agents over a period of time. We look at the experience in the workplace because we do have right of entry under the Occupational Safety and Health Act. The National Cancer Institute is concerned about a combination of factors that might occur to increase risk for cancer, and we would hope they would work even closer with us in the future than they have in the past.

In addition, NIOSH in its laboratory studies would be concerned abmout cancer causation involving a mixture of substances found in the workplace, whereas, the National Cancer Institute in its laboratory studies is concerned about the effects of single agents causing cancer.

The National Institute of Environmental Health Science has been a pioneer in developing screening tests for cancer-causing chemicals. NIOSH would apply those tests to chemicals in the workplace or to biological materials collected from workers to see if workers had been exposed to these agents, and NIOSH would apply these tests to a mixture of materials found in the workplace. So I think there is a clear definition of roles that enable us all to work together and get our work done.

NIOSH PHYSICAL FACILITIES

Mr. MICHEL. Are you satisfied with that Cincinnati center?

Dr. FINKLEA. It is my understanding that the Secretary testified to that effect last week.

Mr. MICHEL. I didn't hear the reply.

Dr. FINKLEA. I said it was my understanding the Secretary had testified to that question last week, sir.

SPECIALTY RECRUITMENT FOR OCCUPATIONAL HEALTH

Mr. MICHEL. You know the charge has been made that there is a recruitment problem in Cincinnati. Is there really a problem? I know there has been a case where a number of increased slots have been allocated to the Cincinnati facilities which may take some time to fill.

Dr. SENCER. If you look at what is happening, Mr. Michel, I said we had 118 vacancies but 100 of those have just been made available to us after the veto was overridden. At the present time we have 379 on duty in Cincinnati, eight committed, for a total of 387, and the ceiling they are working against for their activities in Cincinnati is 32. They are having as much difficulty at Rockville as they are at Cincinnati.

NIOSH TEMPORARY FACILITIES

Mr. MICHEL. Have temporary facilities been provided?

Dr. SENCER. We are in the process of moving into interim facilities at two former EPA sites. These we do not look at as the solution to our facility problems but it at least gets us out of the hazardous space that we are in at the present time.

Mr. MICHEL. Moneys have been appropriated to construct a new environmental health facility in North Carolina. Since the NIOSH activities are somewhat similar, what is the argument against putting those both under the same roof?

Dr. FINKLEA. I think the site selection committee did look at the Research Triangle Park, and I think there are two problems there. One problem is the air transportation that is available to get to the worksites that we have around the country. Another one of course would be the relocation of large numbers of people out of our current community in Cincinnati. There are advantages in colocating with Federal laboratories engaged in similar activities. There is a similar EPA research center in Cincinnati that also works in health research and environmental medicine in addition to the departments planned in North Carolina. You know there is an EPA facility there, so both are good locations, but for our purposes we would have some travel difficulties in operating out of North Carolina.

Mr. MICHEL. I don't have any real strong feelings one way or another. I know you get the argument on the one side where we ought to have all this concentrated in one area, and, by the same token, if this were the case, whoever got the first facility would then get the second, third, fourth, and fifth, there would be no end to it. Our form of government is not the most efficient by any stretch of the imagination, and you run into these other considerations from time to time. I can very well argue that in my home State of Illinois we would like to have something out there and get started, and then we can build upon it.

Dr. FINKLEA. I lived in North Carolina, it is a delightful place in which to live and work.

VENERAL DISEASES

Mr. MICHEL. I note these 125 reductions in positions under the venereal disease program again, and that concerned me, because I recall those early days when we were struggling to get simply $1½ million for VD. In one of your answers to the chairman's questions you said the most serious incidence was still prevalent, as I understand, in Florida and California.

Has the warm weather anything to do with that?

Dr. SENCER. In our discussion of health education we mentioned that a lot of our health problems are related to lifestyle, and I think you find people with certain lifestyles who tend to concentrate in these areas.

Mr. MICHEL. You say the increase is in the male population and is declining in women? Do we have a particular problem in encouraging the treatment of men rather than women? Are men more reluctant to come to a clinic?

Dr. SENCER. As we discussed last year, the homosexual population is experiencing quite high rates of syphillis, and many of our health care delivery systems are not geared to meet their needs. They feel discriminated against. We have been making concerted efforts in the past year to encourage alternative ways of delivering health care to this particular population. For example, we have encouraged the actual establishment of clinics during homosexual conventions, and this has been met with a great deal of success. The medical profession and the health care profession have been pretty stodgy in the past, and to get the reversal and to get people to accept others who are different has made it easier for homosexuals to get into the treatment system.

Mr. MICHEL. Has there been any increase in those two States, Florida and California, of their own money being put into that program in order to eradicate venereal disease.

Dr. SENCER. I can't give you the figures. I think we could generalize we have not been too successful in getting increased expenditures from State governments.

Mr. MICHEL. From any State?

Dr. SENCER. Yes. This is sort of a general statement. We can certainly check and provide it for the record on those two specific States.

Mr. MICHEL. Feel free to expand in the record.

[The information follows:]

VENEREAL DISEASE CONTROL—ESTIMATED STATE CONTRIBUTION, CALIFORNIA AND FLORIDA

| Fiscal year | California | Florida |
|---|---|---|
| 1972 | $470,000 | $60,000 |
| 1973 | 563,000 | 60,000 |
| 1974 | 563,000 | 360,000 |
| 1975 | 563,000 | 400,000 |
| 1976 | 563,000 | 476,000 |

Mr. MICHEL [continuing]. I haven't really checked it out to see if there is any debate on the subject, but I don't know why they consider it to be so much of a Federal problem when they have an obligation healthwise within their own States to do something, particularly if the two States that you make mention of here have a more serious problem. It would seem to me those State legislators ought to do something in a more aggressive way in those two States if that is a growing problem.

Dr. SENCER. I think we have been up against the problem of diminishing support to State health departments in many States in the last 2 years because of the economy.

Mr. MICHEL. How about in the area of revenue sharing; what is the matter there? The Governors are all for it. Why don't they use some of those funds for this purpose?

Dr. SENCER. I understand that there has been a reluctance in the field of health to put revenue sharing funds into activities that have to be ongoing because of the relative uncertainty of continuing support.

Mr. MICHEL. I go back to our debate the first time revenue sharing came before us in the House. I argued that if you adopt it, there is no turning back, because you have just built in the most perfect lobbying

organization throughout the country in every township, county, city, every local entity of government, and once you start it you are never going to turn back. I submit that is exactly what is going to happen. I think we are committed to it foreover.

Mr. FLOOD. If the gentleman will yield.

Mr. MICHEL. Yes.

Mr. FLOOD. I want to repeat again. Do you remember a few years ago when you and I went on about this VD thing in this committee, that you were optimistic about what was going to happen and we kept pounding at you?

Mr. MICHEL. Mr. Chairman, I remember it specifically because he had that Army panel and he was really coming down hard and we were coming at it from the civilian point of view.

Mr. FLOOD. You were the pigeon.

Dr. SENCER. Yes. I still am. When the gonorrhea problem first began to become acute and we did get funds to do something, the first priority was asymptomatic women, and we organized large-scale screening programs to identify this population group. We have been able to narrow down now, and we don't need our screening programs to be as all encompassing, because we know certain populations are going to have higher incidence than others.

As a result of our treatment monitoring program, of seeing what is the best therapy, we have found there is another population group that contributes an inordinate amount of gonorrhea. These are people who have been adequately treated but 3 weeks later you will find 20 percent of them are reinfected. Now we are concentrating efforts on this group using educational techniques to get them to refer their sexual partners in for treatment so we can begin to break the chain of transmission. I would not guarantee that we are going to turn the corner on gonorrhea. I do think we have slowed the rate of increase.

Mr. FLOOD. You remember I used the phrase the Armed Forces kick around all the time: "Ladies, you can cure every disease except the first one," and they kept pounding and asking about this.

Dr. SENCER. You cure them.

Mr. FLOOD. The first one.

Dr. SENCER. If the individuals come to treatment you can cure the first one, and it is only by curing the first one that you will prevent the second one.

Mr. MICHEL. What age group is the biggest group?

Dr. SENCER. The older teen-age and twenties, the sexually active population in both syphilis and gonorrhea.

### RAT CONTROL

Mr. MICHEL. What kind of solid arguments can you give us for reducing funding for the rat control program?

Dr. SENCER. There are a good number of the projects that have gone into their sixth year. When this program was started it was a demonstration project, it was not to be a continuing process, and there are 22 projects that are still going after 6 years. We have been doing better in rat control I guess than in venereal disease control in getting local support. Over 65 percent of the moneys in these programs now come from local contribution. In the first years of operation, about 25 percent was local.

Mr. MICHEL. But not State? Local governments, right?

Dr. SENCER. It will depend upon the State. It depends upon the way the jurisdictions are set up. In New Jersey there has been State money that has been going into municipalities to help in the programs.

HOSPITAL INFECTIONS

Mr. MICHEL. One final question here on staph infections. You say there are roughly 1½ million people spending 7 additional days in the hospitals as a result of staph infections, and yet we are supposedly making such significant advances in medicine and rehabilitating our hospitals and building new ones. How do you account for this?

Dr. SENCER. These are not only staphylococcal infections. When hospital infection first began to attract attention, staph was the big problem, and it had perhaps a bigger environmental factor than others. But as you say, we are making advances in medicine. As we make advances, we are intubating people and putting catheters in them, and these are adding ways in which infections can develop.

In the treatment of cancer we are using suppressant drugs, and this makes people more susceptible to infection, so many of the advances we have made have also been some of the causes of some of our difficulties.

Mr. FLOOD. Mr. Natcher.

PROJECT GRANT POSITIONS

Mr. NATCHER. Doctor, on page 122 of your justification you show a reduction of 150 positions for project grants. What is the reason for this reduction?

Dr. SENCER. This reduction is based on the fact that it is believed that the States should take more responsibility and not use Federal personnel in helping them implement their disease control activities.

Mr. NATCHER. What kind of people would be dropped from the roles if this reduction is approved?

Dr. SENCER. These are Federal employees who are principally in the category we refer to as public health advisers. These are people who are intimately concerned with helping the States organize and operate disease control activities.

Mr. NATCHER. What impact will this reduction in positions have on public health programs in the States?

Dr. SENCER. It is our hope that the States would replace these Federal positions with State people that would continue the same type of activity.

Mr. NATCHER. Doctor, your appropriation language gives you authority to conduct training programs for employees of Federal, State, and local governments as well as employees of private agencies. What kind of training courses do you conduct and how many people do you train annually, approximately?

Dr. SENCER. Our training courses are short-term training activities, both didactic—lecture, formal courses, et cetera—and bench training, where people are trained at the laboratory bench. In fiscal 1975 we trained over 1,500 individuals in organized formal training both at the bench and in classrooms.

Mr. NATCHER. Some people have told us that the requirements in the law that you recover the full cost of training may result in States

and local governments not sending their employees for training. How expensive are your courses, Doctor?

Dr. SENCER. We can give you a range. Some courses such as our courses in virology will cost as much as $400 a student. Others would be as low as $25. But the bench courses, because of the equipment and the materials that are necessary, are quite expensive.

Mr. NATCHER. Assuming now that the people stopped attending your training program in the laboratory procedures. What impact will this have on the quality of work conducted in the State laboratories?

Dr. SENCER. We have been able to equate improved laboratory services with people attending our training courses. For example, 2 years ago we put on training for all State public health laboratories in the diagnosis of cholera. As a result of this training the laboratories are now looking for new organisms and are finding new causes of outbreaks of food poisoning, and have identified cholera. We found the same to be true when we developed a blood test for German measles. We trained individuals from all State health departments, and they are now capable of doing this type of serology.

Mr. NATCHER. Doctor, given the shortage of resources at both the State and Federal level, do you have any suggestions on how you can arrive at a mechanism to more equitably distribute the cost of this training?

Dr. SENCER. Our policy in the past has been to charge people who were coming from private enterprise to take training, on the basis that they had mechanisms of collecting under third-party reimbursement and so on where training is an eligible expense. But State and local official agencies do not have this mechanism for obtaining funds to support training and have had a waiver, no longer available.

### NIOSH MANPOWER AND TRAINING

Mr. NATCHER. Doctor, with regard to the manpower needs of the National Institute for Occupational Safety and Health, can you tell us how many people are currently in training for careers in this field?

Dr. SENCER. We can for programs supported by Occupational Safety and Health. I think Dr. Finklea went through this. This is about 1,100, I believe.

Dr. FINKLEA. In terms of the short-term training, sir, it would be about 1,200. In terms of long-term training, it is about 705.

Mr. NATCHER. Seven hundred and five?

Dr. FINKLEA. Yes, sir.

Mr. NATCHER. How many of these individuals are federally supported?

Dr. FINKLEA. 150, sir.

Mr. NATCHER. How many university-based training programs are there for training Occupational Safety and Health personnel?

Dr. FINKLEA. We have approximately 50 training grants that were awarded plus those that were awarded in the last fiscal year that would be phased out with the current budget. There are not a large number of programs that are funded by mechanisms other than the Federal mechanism.

Mr. NATCHER. Can you tell me how many are being formed at this time and what is the total number of people that these programs will produce annually? Can you give me a figure there?

Dr. FINKLEA. I think we feel that the federally supported programs for people in occupational nursing, for physicians, and for industrial hygienists constitute the great majority of programs that are present in the country, and I gave those figures a little earlier. In addition, there are training programs in the Armed Forces for industrial hygiene and for certain specific kinds of occupational medicine that are approximately equal to those in the private sector.

### HEALTH EDUCATION

Mr. NATCHER. Doctor, whatever happened to the idea of developing a National Center for Health Education? We used to hear that discussed from time to time. What happened to this idea?

Dr. SENCER. The National Center for Health Education was chartered about 6 months ago. This is a coalition of groups of people in the private sector who have come together in a loose coalition to try to integrate and coordinate some of the multitudinous health educational activities that go on in the voluntary associations, insurance industry and the various provider groups.

### PROGRAM VALUE

Mr. NATCHER. Doctor, do you back this program? Do you think this is a worthwhile idea? Do you feel that the education programs as they exist are adequate?

Dr. SENCER. In the early days, I was very skeptical that we could ever get the private sector to come together into this type of a coalition. We did financially support the development of it, and I must say I am very surprised and very pleased that this has happened. I fully support it because we do have a tremendous amount of competition for the attention of people, rather than trying to bring coordinated messages to the general public.

### CRITERIA DOCUMENTS

Mr. NATCHER. Doctor, what about criteria documents; how are they prepared? Give us some idea and tell us how much of the work is in-house, how much of it is under contract. Give us some idea as to the cost per document.

Dr. FINKLEA. Yes, sir. The criteria documents that we have prepared in this and subsequent years will be prepared about 75 percent by contract, about one-quarter intramural. We endeavor to prepare those documents which are likely to be most controversial within the Federal Government. For those documents which are likely to cause somewhat less controversy, we will rely heavily upon the contract mechanism.

Mr. NATCHER. Doctor, why does it take so long to prepare these criteria documents?

Dr. FINKLEA. One of the primary reasons in the past has been the fact that a number of outside reviews were held sequentially in order to assure a quality document would be produced. We have since undertaken reforms in the system. We will be producing criteria documents on an average we hope of between 26 and 30 weeks instead of the documents that take a year or longer to produce, so we hope to have

the time needed to prepare documents, and we hope that these documents can address a number of like agents rather than a single agent in the workplace.

Mr. NATCHER. What percentage of all cancers in the United States would you say are caused by exposure to substances in the workplace?

Dr. SENCER. If we could expand that to talk about those that have a relationship to the environment, I think the estimate has been as much as 80 percent of the cancers that occur are related, or we will eventually relate back to environment exposures of one sort or another.

Mr. NATCHER. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Obey.

INFLUENZA

Mr. OBEY. Thank you, Mr. Chairman.

Doctor, I talked to Dr. Sabin, I have forgotten when, 5 or 6 months ago I think, and he was concerned at that time about the potential outbreak of influenza that would be very serious in this country emerging at that time, in addition to the budget for Infectious Diseases Institute at NIH. Could you sort of recite what his concerns are, what his position is versus yours?

Dr. SENCER. I don't think there is any difference in position. I talked to Dr. Sabin Friday night about this. We do know that influenza is cyclical, that it occurs in pandemics, that come every 10, 15 years. It is very difficult to say precisely how many years. Our last major pandemic was in 1968–69, the so-called Hong Kong flu, and before that the Asian flu of 1957–58. So it looks like it is running about a 10-year cycle.

Many investigators both at NIH and elsewhere have been working with live virus influenza vaccines. The vaccines that we currently use is a killed virus vaccine. The mechanism of developing a live virus vaccine is to select a strain that does not have all the virulence that normally occurring influenza does, to attenuate the virus in a variety of different manners, and then to develop a live attenuated virus vaccine. The one advantage, investigator's believe, is ease of production of vaccine rather than any increased efficacy of vaccines. In field trials that were conducted last year we found the live virus and the killed virus vaccine were equally effective.

We have had a variety of meetings jointly with NIH and the Bureau of Biologics, and with industry reviewing the possibilities. We had such a meeting in January. We all agreed that research must continue in this area, but that the state of the art is not such at the present time that a crash program for developing a live virus vaccine is scientifically feasible. We do have sufficient leadtime and industrial capability to produce a killed virus vaccine by next fall, if needed to deal with the new swine strain.

Mr. OBEY. So it is your feeling that the action being taken now is adequate to protect the country?

Dr. SENCER. Yes. It is not only my opinion but that of NIH and the Bureau of Biologics.

Mr. OBEY. You don't think there is any work which should be done which can not be done under present circumstances?

Dr. SENCER. We think during the coming several months the opportunity for very important research will be available. A meeting was held last week with all of the investigators in influenza to outline the situation and to enlist their cooperation in doing the things that needed to be done in the coming weeks.

Mr. OBEY. So you are satisfied that the budget both in research and anyplace else is adequate to do everything we ought to be doing that is necessary to prepare for it?

Dr. SENCER. At the present time I would say yes, sir. I would not say from a professional standpoint that the coming weeks may not make me change my mind.

Mr. OBEY. What makes you say that? I just want to make sure if we vote on this budget that we are not open to the criticism later that we should have been more alert to building potential for this problem.

Dr. SENCER. We do not know the significance of the recent isolation of influenza as the swinelike type.

Mr. OBEY. How soon do you think it will be?

Dr. SENCER. I think we will have information in the next 2 to 3 weeks which will point us in which direction we should go.

Mr. OBEY. If you do get information there might be a more serious problem than you originally thought, what will you do? Will you let this committee know?

Dr. SENCER. I will let the Department know, yes, sir.

Mr. MILLER. We had a similar problem with rubella, Mr. Obey. We did come back with a request for additional funds. I think if this situation proves that dangerous, we would do that.

Dr. SENCER. We did that when polio vaccine was first licensed in 1955 and the live virus in 1962.

BIRTH DEFECTS

Mr. OBEY. Let me ask you some questions about the Division of Cancer and Birth Defects. How many people are in that division?

Dr. SENCER. There are 34.

Mr. OBEY. How many are working full time, and how many are away at school?

Dr. SENCER. There is only one professional staff that is in training at the present time.

Mr. OBEY. What are those figures for next year?

Dr. SENCER. No change.

BIRTH DEFECTS

Mr. OBEY. Let me ask a question which relates to page 130 of the justifications regarding the Division of Cancer and Birth Defects. Are there any conflicts between the people at CDC doing the kind of work you have described on page 130 and the people at NIOSH who it would seem have very similar responsibilities.

Dr. SENCER. It depends on what you mean by conflict. I think there are some professional differences of opinion as you would expect in any organization. I think that sometimes in the past we have not

been as well coordinated as we could be, but I think the recent series of meetings that we have been holding between the two groups has minimized this. There is quite close collaboration at the present time.

Mr. OBEY. You don't think there are any undue tensions between those two groups?

Dr. SENCER. I think there are tensions, but not undue. A little tension is a way by which progress is made.

PROGRAM COORDINATION

Mr. OBEY. On page 130 you indicate you are doing work on viral clusters and lung cancers among vinyl chloride workers, and angiosarcoma. We already spend a lot of money on that in NCI, NIOSH and NICHHD. Why do we need your program?

Dr. SENCER. Our program was started and is continuing to be supported by the National Cancer Institute in terms of an interagency agreement. We are able to recruit, train, and maintain epidemiologic competence, and they have asked us to do this type of work. We have interagency agreements in this area from both the Cancer Institute and the National Institute of Child Health and Human Development. Regarding work in vinyl chloride, the current investigation in Wissonsin is being conducted jointly by staff from Cincinnati and Atlanta

Mr. OBEY. When did the project which you describe on viral clusters begin?

Dr. SENCER. The clusters of leukemias?

Mr. OBEY. Yes.

Dr. SENCER. This is quite old. The first one that come to light was in 1961 in Niles, Ill. Actual continuing investigation of such clusters has continued for the Cancer Institute since about 1967.

Mr. OBEY. How much has been spent so far total?

Dr. SENCER. I would have to supply that for the recrod.

PROGRAM COST

Mr. OBEY. Do you have any idea?

Dr. SENCER. It is not just for the clusters. Our reimbursement is running at a level of about $110,000 a year.

Mr. OBEY. What are the results? I have been told by some people the results indicate the whole project is a flop.

Dr. SENCER. The Cancer Institute asked us to continue with the project. We have been able to identify certain characteristics in populations where there are clusters. The significance of these can only be adjudged after more and more of these clusters are developed.

Mr. OBEY. Would you submit for the record a short summary of findings with respect to this?

Dr. SENCER. Certainly.

[The information follows:]

AMOUNT SPENT FOR LEUKEMIA CLUSTERS

A breakdown of National Cancer Institute's support of Center for Disease Control's cancer epidemiology studies, along with an estimate of CDC's input and of total annual medical manpower requirements, are as follows:

| Fiscal year | NCI reimbursable | CDC funding [1] | Total medical epidemiologist manpower (man-years) |
|---|---|---|---|
| 1968 | $85,200 | $21,300 | 4.70 |
| 1969 | 86,900 | 21,725 | 5.00 |
| 1970 | 79,740 | 19,935 | 5.00 |
| 1971 | 144,200 | 36,050 | 4.70 |
| 1972 | 150,000 | 37,500 | 4.70 |
| 1973 | 101,640 | 25,410 | 3.40 |
| 1974 | 149,760 | 37,440 | 4.50 |
| 1975 | 120,576 | 30,144 | 3.00 |
| 1976 | 110,000 | 27,500 | 2.50 |
| Total | 1,028,016 | 257,004 | |

[1] Estimated as averaging 25 percent of NCI funding over 9-yr period.

### SUMMARY OF FINDINGS ON LEUKEMIA CLUSTERS

Epidemiologic studies of cancer at the Center for Disease Control were first begun in the late 1950's primarily because of CDC's long-standing expertise in viral disease epidemiology and the then prevalent scientific concern that at least some kinds of cancers might have a viral etiology. CDC's objective was to determine whether certain cancers are of viral etiology and therefore communicable. If viral etiology was established, efforts would be made to develop prevention and control measures.

The continuing need for further understanding of cancer etiology and the ultimate aim of prevention and control have been shared by the National Cancer Institute, to the extent that beginning in 1967 NCI began underwriting approximately three-fourths of our efforts in cancer epidemiology. Such efforts, were NCI to have undertaken them themselves, would have entailed a duplication of both CDC's specialized competence in viral disease epidemiology and its unique competence in epidemiologic field investigation embodied in the Epidemic Intelligence Service.

Activities directed from CDC in Atlanta, under what is now the Cancer and Birth Defects Division, Bureau of Epidemiology, have covered a range of epidemiologic areas relevant to the human viral oncology question, and are outlined below.

### EARLY EPIDEMIC FIELD INVESTIGATIONS

Epidemiologic studies at CDC bearing on the possible viral etiology of cancer date from the late 1950's, when periodic epidemic-aid-type field investigations of childhood leukemia case clusters were first undertaken (Bergen County, N.J., 1957; Niles, Ill., 1961–62; Green Bay, Wis., 1963–64). In the mid-1960's, sustained epidemiologic programs in viral oncology were first begun.

### TIME-SPACE CLUSTERING

At first, work focused heavily on field investigation of leukemia or lymphoma case clusters, together with statistical studies of time-space clustering among cases in various parts of the United States. Limited leukemia/lymphoma case surveillance projects were fostered to support this work (metro Atlanta, metro Houston, Nassau County, N.Y., Alameda County, Calif., and the States of Colorado, Connecticut, Rhode Island, Utah, and Washington). Three of these surveillance projects still continue (Atlanta, Houston, and Rhode Island).

The study of time-space clusters was a first epidemiologic step in the direction of conceptualizing how infectious agents might influence cancer development, a step that in retrospect may seem rather simplistic. Actually, however, the issue of time-space clustering has yet to be satisfactorily resolved. Several analytic studies on the question, one from CDC work in Atlanta, suggest a weak clustering tendency among cases of childhood acute leukemia. Basically, the statistical techniques for testing this hypothesis are severely limited (they would fail, for example, to show clustering for various known infectious diseases such as infectious mononucleosis); we await new ideas, perhaps help from laboratory research. In the meantime, the statistical studies so far conducted, together with various

carefully documented episodes of community case clustering studied by CDC in various parts of the United States continue to suggest that time-space clustering may have etiologic significance for various forms of human leukemia or lymphoma.

INTERPERSONAL CONTACT AS A POSSIBLE RISK FACTOR

More recently, epidemiologic attention has shifted to the much more complex question of leukemia/lymphoma case "clustering" in terms of interpersonal contact among cases, direct or through intermediary contacts, over extended periods of time. Various individual case groupings investigated by CDC in particular U.S. communities have suggested this idea, and since 1973 a systematic analysis of past high school attendance patterns among cases of leukemia/lymphoma in Connecticut has provided objective support for this hypothesis of intercase contagiousness. A current CDC study research along these lines, with NCI support.

MULTIPLE CASE LEUKEMIA/LYMPHOMA FAMILIES

Epidemiologic research in viral oncogenesis at CDC has also taken the form of family studies. Numerous famiiies containing multiple cancer cases, primarily cases of leukemia or lymphoma, have been traced with tissue and blood specimens from these families used to examine antibody patterns as well as immunologic response. Studies of Epstein-Barre Virus antibody patterns in some of these families are in progress in collaboration with NCI, while detailed analysis of one extended family in association with Duke University has suggested a connection between immunologic competence and susceptibility to lymphoreticular tumors.

ASSOCIATION OF ANIMAL LEUKEMIA TO HUMAN CANCER

In the past several years, the question of animal cancer virus contagiousness for humans has received our particular attention. In a joint study with Harvard University and the Angell Memorial Hospital in Boston, persons in household contact with cats known to be shedding Feline Leukemia Virus have been found in fairly high proportion to have probable antibodies against Feline Leukemia Virus. This work, which is still ongoing, strongly suggests that, contrary to usual thinking, animal oncoviruses may be able to cross species bounds to infect man.

CANCER AS A SEQUEL TO INFECTIOUS DISEASE

The role of viruses and of predisposing or "triggering" infectious disease episodes remains unclear in terms of human cancer causation. The need to continue studies of these matters, however, remains quite clear. Significant work has been carried out concerning cancer as a sequel to recognized episodes of infectious disease. Analysis of data from the Atlanta and Houston areas showed no increase in risk for childhood leukemia/lymphoma in relation to in utero exposure to influenza. In a retrospective cohort study recently completed in collaboration with NCI, the American College Health Association, and several U.S. universities, evidence was obtained to support indications in studies elsewhere that Hodgkin's disease may occasionally be a late sequela of infectious mononucleosis.

INDUSTRYWIDE STUDIES

Mr. OBEY. You told the chairman earlier that the results of your industrywide epidemiological studies are transmitted to a wide variety of people including the Department of Labor. A few weeks ago I asked Dr. Corn about an industrywide study conducted by your agency which I read about in a magazine on anesthetic gas. Dr. Corn had indicated that there was no standard on anesthetic gas, that he received no formal transmission concerning this work hazard from HEW. Are you familiar with that, sir?

Dr. SENCER. I am familiar with the study. This was done under contract with the Anesthesiology Association. There have been a good number of preliminary papers presented on it.

Dr. Finklea, do you want to elaborate?

Mr. OBEY. My question is, why hasn't there been communication to OSHA? As I understand, it is required under the OSHA act.

Dr. FINKLEA. I think the OSHA people have been briefed on it, and they have also been briefed on the criteria backing the schedule. There is a criteria document being developed.

Mr. OBEY. I understand that, but the obligation under the law is to immediately inform the Department of Labor when you find a potential hazard on a substance for which no standard has been set. Dr. Corn says he was not informed.

Dr. FINKLEA. I think the Department of Labor has been informed of this study before Dr. Corn's coming last December. This was discussed before I came in a year ago.

Mr. OBEY. I would appreciate it if you would get together with Dr. Corn and let us know what the answer is on this.

Dr. SENCER. We will.

Mr. OBEY. He indicated to us they had not been formally notified.

Dr. SENCER. We will document what has been done, and if there are deficiencies we will correct them.

[The information follows:]

DISTRIBUTION OF HAZARDOUS SUBSTANCES LISTS

Following the initial studies of adverse health effects, attributed to anesthetic gases, several questions were raised by scientists from three health agencies in Department of Health, Education, and Welfare. While these epidemiological questions are being resolved, National Institute for Occupational Safety and Health has scheduled a work practices recommendation which should be delivered to the Department of Labor later this year. We have previously advised the Department of Labor of the projected transmittal of the recommendation. In addition we routinely transmit information on substances which are not currently regulated to the Department of Labor when we acquire information that indicates an unregulated agent could pose a health risk. Three transmittal mechanisms are employed: memos addressing specific problems, health hazard evaluation reports and our occupational health alerts.

KEPONE INCIDENT

Mr. OBEY. Last month as you know, I issued a statement criticizing your agency for failure to comply with the OSHA act in your handling of the kepone situation. Your testimony before Senator Allen's committee was interesting. You said that the Division of Cancer and Birth Defects learned about kepone being in the blood of workers on July 19 and began making plans to research the situation. Can you tell me when you notified NIOSH about that problem and when you notified OSHA?

Dr. SENCER. I would be glad to review the chronology of this for you, Mr. Obey. A blood specimen was sent to our laboratory on the 10th of July by a physician in Hopewell, Va., with a request that it be analyzed for Kepone. When Dr. Kimborough, our toxocologist, found an extremely high level of Kepone in the blood, she notified Dr. Heath of our staff with the feeling that this was too high to be an industrial exposure; she thought there was something wrong. On the 22d of July Dr. Heath notified the Virginia State Health Department of this finding, and asked if they could coroborate whether this was actually an industrial process. On the 25th of July, the State of Virginia closed the factory because of its work practices. On the 8th of August we were invited by the State of Virginia to participate in

the investigation, and at that time notified NIOSH of this invitation, and requested their participation.

I can see why some people might think this is an inordinate delay, but we must also remember that the enforcement agencies had been notified 18 months before with a complaint that the factory was dangerous and nothing had happend. As a result of notifying the State health department the factory was closed in 3 days.

Mr. OBEY. What is wrong with notifying both?

Dr. SENCER. We have set up a procedure now so that this 6-day delay won't take place again. I can't guarantee it, but we have a procedure that I think has been working in the last several months.

OCCUPATIONAL HEALTH STUDIES

Mr. OBEY. As I understand, Dr. Finklea testified before Congressman Daniels committee that NIOSH would take the lead in all occupational studies. Would you give us a copy of that statement for the record?

Dr. FINKLEA. Yes.

[The information follows:]

The following is quoted beginning with page 8 of Dr. Finglea's statement before Congressman D. V. Daniels Committee on February 9, 1976:

"In reviewing the events surrounding this tragedy, it is obvious that we at NIOSH and others in public health need better access to information about potential health hazards and we need to respond more quickly once we are aware that a hazard exists. We have taken steps to develop a better health intelligence system. We have met with representatives from OSHA, FDA, and EPA to set up procedures for sharing information and for coordinating responses to health emergencies. We have arranged with NCI to obtain results of their bio-assay testing program more quickly. Even before they produce a final technical report, NCI has agreed to provide NIOSH and other Federal agencies with preliminary information on chemicals as soon as possible after completion of the studies.

"We have also made the following changes in our internal operations.

"1. To ensure that we avoid any possible delay in protecting workers, other components of CDC will notify NIOSH immediately when they learn of illness that is known or suspected to be the result of occupational exposure. NIOSH will take the lead in conducting the subsequent investigation.

"2. The NIOSH health hazard evaluation program is being expanded to be more responsive to requests for field investigations. To provide the necessary manpower CDC had designated 14 Epidemic Intelligence Service (EIS) officers, assigned to the various State health departments, to assist NIOSH industrial hygienists and physicians in conducting these evaluations. We are also expediting the process of preparing and disseminating hazard evaluation reports.

"3. NIOSH has developed a system for issuing current intelligence bulletins when we receive new information on potentially dangerous chemical substances. In 2 to 4 weeks we can provide background information on the chemical, including its known toxicity to man and animals, known producers and users, estimated extent of occupational exposure, and further action planned by NIOSH. Those bulletins are now being distributed to 1200 representatives from the occupational safety and health community, other Government agencies, management, labor, and public interest groups.

In conclusion, I would like to assure that one aspect of the tragedy in Hopewell is not overlooked. Although NIOSH is primarily a research institute and OSHA is primarily a standards setting and enforcement agency, together we have the mandated responsibility to provide an adequate supply of qualified personnel to carry out the purposes of the Occupational Safety and Health Act. Together we need to renew our efforts to educate professionals in the basic principles of industrial hygiene and occupational medicine, and to train employers and employees in the recognition, avoidance, and prevention of unsafe or unhealthful working conditions."

[Mr. Early assumed the chair in the absence of Mr. Flood.]

COMMUNICABLE DISEASES

Mr. EARLY. We will resume the hearing.

Doctor, in your statement would you describe the field tests for controlling measles that you say will be conducted in one section of the country?

Dr. SENCER. At the present time we are utilizing some of the techniques used in smallpox eradication to see if these are applicable to measles. I won't use the word eradication but at least better control than we have at the present time.

We are working with five States in the Midwest in a system of early warinng, if you will, of the first case of measles at a school, and then we converge on that community and do immunization.

Mr. EARLY. What are those five States?

Dr. SENCER. Michigan, Illinois, Wisconsin, Indiana, and Ohio, which are in Public Health Service region V.

Mr. EARLY. Where is the one test that is being conducted?

Dr. SENCER. These are communitywide studies. Wherever there is an outbreak, we try to rapidly bring it under control so it doesn't spread out into the community.

Mr. EARLY. In your statement you say a new strategy for measles identification is being field tested in one section of the country.

Dr. SENCER. It is in HEW region V.

Mr. EARLY. What is the new strategy?

Dr. SENCER. This is a strategy of increasing our surveillance to pick up early indications and then vaccinate around them. Rather than trying to vaccinate everybody, we concentrate on the outbreaks and contain them.

Mr. EARLY. This is for early identification?

Dr. SENCER. Yes. We are still promoting early immunization of all children, but this is an additional strategy.

Mr. EARLY. What is the present program for detection and what is the new strategy?

Dr. SENCER. The new strategy is combining the early detection with the control. The usual method of reporting is that physicians once a week will call the health department and give them the number of cases that they have had. We are now encouraging telephoning and immediate report of the first case of measles that is suspected.

Mr. EARLY. Is there manpower available in the underserved areas of the country to do that?

Dr. SENCER. Public health nurses and other health manpower are temporarily diverted to control an outbreak. It is not requiring large additional manpower resources.

Mr. EARLY. Will the poverty-stricken areas have the same advantage?

Dr. SENCER. Most of the work is going on in the central cities because this is where the epidemics are occurring, so the manpower is being put in there to do this.

DISEASE SURVEILLANCE

Mr. EARLY. How does CDC pinpoint the areas with the high disease rate?

Dr. SENCER. We have a variety of mechanisms of reporting. We have a system that once every Tuesday every State sends us a telegraphic report of the incidence of diseases in their jurisdiction during the previous week. We have special surveillance programs of about 30 to 40 different diseases where we are getting individual case reports from the State and local agencies. There are some diseases that are important enough and rare enough that people pick up the telephone and call right then, diseases such as plague, botulism, and anthrax, that are of low frequency but very serious if not controlled.

Mr. EARLY. Is it true, Doctor, the poor areas don't have the vaccines or rarely are the areas that get the vaccination and immunizations?

Dr. SENCER. I think just about every health problem you can find accentuated in underserved areas, yes, sir.

Mr. EARLY. What are we doing to improve that situation?

Dr. SENCER. I can only speak just to infectious disease problems. Our principal constituents are the official agencies, and it is a question we are very acutely aware of because this is where our disease problems are occurring.

STATE PARTICIPATION

Mr. EARLY. But it doesn't seem to be that way. In answer to every one of the members you state that the States are picking up, and you are submitting a budget that is going to put us in a program that calls for more State participation.

Dr. SENCER. I think right here I was referring to an acute problem. If there is an outbreak of disease you stop doing other things to attempt to control it. I think the concern is that there should be more State supported ongoing activity rather than just the continuing Federal support of it.

Mr. EARLY. My whole approach, Doctor, is that we spend too much money after the fact and we go after the problem and not the root of the problem. But I would think CDC would do just the opposite—would be going after the roots of the problem.

Now we have preventive medicine which is probably the most constructive we could have. How can you explain only 17 States requiring screening for lead paint poisoning?

Dr. SENCER. That is required as one of the things included in EPSDT. There are a variety of screening programs other than that. As you know, EPSDT, under the medicaid program, is a highly decentralized program, and there is not much in terms of central direction.

Mr. EARLY. How many of the States not requiring it are actually doing more than just the rules and regulations and putting it on the books but are actually doing it?

Dr. SENCER. I can submit for the record the figures we have on the number of examinations being done by State.

[The information follows:]

LEAD SCREENING EXAMINATIONS BY STATES FROM OTHER FEDERALLY FUNDED PROGRAMS

| | *Number of tests* |
|---|---|
| Florida | 4,605 |
| Idaho | 148 |
| Iowa | 1,995 |
| Maryland | 243 |
| Michigan | 13,829 |
| Montana | 158 |
| Nebraska | 1,157 |
| Ohio | 935 |
| Cleveland | 3,182 |
| Tennessee | |
| Nashville | 326 |
| Texas | 237,365 |
| Houston | 9,698 |
| Wisconsin | 1,773 |
| Milwaukee | 161 |
| Total | 275,575 |

The childhood lead poisoning prevention projects, which have reported the screening of approximately 1,090,00 children, have worked closely with the other federally financed child health programs on the local level. The results of the joint cooperative efforts have been incorporated into the lead program quarterly reports. Efforts are being made to intensify the exchange of data regarding lead screening in areas without a lead project. CDC is in the process of implementing a laboratory quarterly reporting system which will provide information on the results of the analysis performed by 98 laboratories located throughout the Nation.

STATE REQUIREMENTS

Mr. EARLY. The States don't mind requiring they do it if they are doing it. I say the States not requiring it are not actually doing it.

Dr. SENCER. In many of the areas there are other federally supported programs such as the one we defend in our budget where we can tell you what is being done. Unfortunately, the information-gathering system under medicaid is not adequate for us to answer your question.

Mr. EARLY. When you say it is not adequate that is fine, but we are shifting totally away from what we have been doing. I suggest, Doctor, from listening to the testimony, from having read the budget—and I will yield back to Mr. Obey to complete his questions—that CDC and everyone else is giving us two suggestions today.

HEALTH EDUCATION

First of all, you say the National Center for Health Education, which is privately financed, which you were skeptical of before, is now getting involved. Let me ask you this question. Are they getting involved because they see a national health program coming, or do you think they are getting involved because it is the right thing to do?

Dr. SENCER. I think in the area of health education they are getting involved because they have found that by going it alone they are having difficulty capturing audiences, and that they feel there is a need to band together to get messages across to the audience.

Mr. EARLY. What you are telling us is that the private sector probably can get it started but twice as hard after getting a program started is to keep it going, but you are satisfied that the private sector is going to do enough to alleviate your agency of its responsibility?

Dr. SENCER. No, I don't think it will, but I think it will complement the things that we will continue to be doing.

Mr. EARLY. How much funding do they get today, Doctor?

Dr. SENCER. I don't know, sir. It is in the millions.

Mr. EARLY. You said it was from the insurance sector?

Dr. SENCER. From insurance, from the voluntary agencies, and from the professional societies, and so on.

Mr. EARLY. Do you have a skepticism of a voluntary-type program in this type of field as far as the insurance companies especially? Are they going in again fearing national health insurance?

Dr. SENCER. I don't think that it is from fear. I think they see this also as a way in which they can emphasize some cost containment also.

Mr. EARLY. You say you saw it 10 years ago.

Dr. SENCER. Our Bureau of Health Education is just a year old now, and this has not been an area that has been given high priority.

Mr. EARLY. Preventive medicine.

Dr. SENCER. In the areas where we had specific preventive measures, we have been able to act. But in the other areas of preventive medicine where it is a question of modifying lifestyle rather than getting an individual to do a specific thing on a one-time basis is something that everybody has thought a lot about.

Mr. EARLY. It is not just a year old.

Dr. SENCER. The Federal Government's concern for a generalized approach to this type of preventive medicine is something that has come about quite recently. I think there is a considerable question in the minds of people just how far Government should go in trying to influence individual behavior.

Mr. EARLY. There is a strong feeling that is an easy way out as far as that is an administration approach right now saying, "Let the private sector do it." I suggest we are doing the same thing in the whole approach you have here. You give us the private sector that is going to pick up some of the bit you are dropping as far as education, then you tell us that the States and local communities are going to pick up more than they have been picking up in the past, although all your testimony shows that the States aren't doing it.

There is no question whether States are going to do it—because they are not. Massachusetts, New York, can't meet their present expenses. They are doing nothing but cutting. They are not going to increase spending. I suggest what we are doing in regard to health via this budget is not looking for cures and not looking to solve the problem. We are looking to get off the hook and find somebody else to blame down the road, and we are not going to be able to blame the National Center for Health Education or the States and local communities for not picking it up.

Would you comment on that.

Dr. SENCER. I hope we are not in a position of assessing blame; that we can find ways of working cooperatively to accomplish the same goals that I would hope that State and local communities would have as we have at the Federal Government.

REVENUE SHARING

Mr. EARLY. That is idealistic that we have at the Federal level. We have more of it down here in the Federal level than we have any place else. We don't look to go forward. We look to blame someone in back of us. I suggest that is what you are doing here when you are suggesting that the States are going to pick up the expense, the States are going to educate their own people that the Feds have evidently been paying for. That is not going to happen.

Mr. Michel asked several questions about revenue sharing. It doesn't go for any new programs. I can only identify my own State because I have just recently been vice chairman of ways and means there. Of the third that goes to the State, 99 percent goes to the indebtedness, and of the third that goes to the cities and towns, up to 90 percent goes to indebtedness, and they are not going to pick up programs that you are telling this committee we can afford to drop. I think it is a very poor approach to it. We see statistics. I can appreciate your agency being upset because they are going up and we are spending the money, but I hope we don't look to find someone to blame, that we just keep progressively charging it and trying to do the right thing.

Let's take the President's consolidation of 16 Federal health programs. Under this program isn't it true that the States will not have to put up matching funds?

Dr. SENCER. The States have not had to put up matching funds for any of the programs that have been in this budget, the immunization, the VD, rats, and lead have not been matching programs.

Mr. EARLY. Wasn't there some State participation?

Dr. SENCER. There is State participation, but no formal matching.

Mr. EARLY. But under this new approach this budget that we have here, there is no State money, is there?

Dr. SENCER. There is no requirement, as I understand it.

Mr. EARLY. If there is no requirement, the State is not going to do it.

Dr. SENCER. I defer to Mr. Miller on this, but the bulk is going to be medicaid money.

Mr. MILLER. This distinction he is making, is that the programs he administers are being proposed for folding into the block grant do not require State matching. Some of the programs do, medicaid being a major example, maternal and child health being another.

You are correct. While the Federal funds will be greater because of the medicaid portion, than in the current appropriation, and thus total Federal funds will be greater, there is no requirement on the States that they have to put up any money for those programs.

Mr. EARLY. Fine, but I am not sure of the first, that the Federal moneys will be greater. They might hold the same, but they are not going to be greater. When you combine 16 with medicaid, they cost you just over $9 billion last year and the total package is only funded at $10 billion.

Mr. MILLER. But the total money that we expect to go out for those 16 programs including medicaid is about $1 billion more than the

1976 appropriations for that amount of funds being associated with the block grant, but that is strictly because of an increase in medicaid.

Mr. EARLY. That is not your 1976 budget that includes the override and everything else.

Mr. MILLER. It is.

MATCHING FUNDS

Mr. EARLY. It would still be $1-billion increase. I can't see how you can suggest, Dr. Sencer, that with no matching funds—I can tell you what my State is going to do, which I think most States are going to do—not put up any money. Now you are going to allow them to spend the Federal moneys the way they see fit, there is little choice of any expansion in any of these programs in which the amounts of the problems are increasing rapidly. You know there is a time for everything. I say if there was ever a worst time to go into this type of program, the block grant program as we see it, it is right now. What this approach is trying to do is to get off the hook and put the responsibility somewhere else. The actual solutions to the problem I suggest aren't going to be improved because the States aren't going to pick it up. People are not going to get better, but we are going to have someone to blame. I really can't understand how we do that. What do you see, Doctor, as far as these programs being grouped together? What do you see the States doing?

Dr. SENCER. Could I answer that by saying what we would propose to do. We would be working intensely with the health planning agencies in the States to try to make sure that the problems that we are concerned with are being recognized as priority problems in the States.

Mr. EARLY. But if you don't regulate those problems it is like talking to the air.

Dr. SENCER. There are certain guidelines that are being prepared for the health planning agencies in which we are trying to build in what we feel are the necessary elements of an overall prevention program, that they should take into account in reveiwing health-funded activities within their State or in their area.

Mr. EARLY. Don't you have the fear that what Mr. Michel suggested happened with regard to revenue sharing will happen with health programs?

Dr. SENCER. I have concern that we not let it happen. We will do the best we can to prevent it.

Mr. EARLY. You are not going to have control on it. We are giving up the control. Anyone that suggests that New York State is going to expand isn't being honest with anybody. They can't pay their debts; the same thing with Massachusetts; the same thing with most of the States.

I can't see how we can go in that direction right now.

Mr. MILLER. Mr. Early, you do recognize that the health block legislation would require the expenditure of those funds at the State level on the health programs. I am not quarreling with you as to whether or not the State will put up what it has formerly put up in matching. But in some respects the comparison with general revenue sharing ignores the fact that these proposals are not revenue sharing. There will be requirements on what the States can spend the money for. There just won't be so many categories.

Mr. EARLY. That is true, but the States already spend the moneys, their own moneys right now in those categories, so I suggest to you that the States are going to take the fed money, and reduce the State share in the categories that they are now paying for. That is the first thing they are going to do.

Then they are going to say, how much do we expand? Then they are going to take the same irresponsible route that we take and say. "Let the private sector do it," or "The Feds have to give us more money." The only thing that is going to happen is that the programs aren't going to be treated adequately. We all know when programs don't get treated the ones that suffer are the poor, the immigrants, the minorities.

I just don't see CDC going in the right direction.

EPIDEMIC INTELLIGENCE

One other question, Doctor. You spoke of this epidemic intelligence force. Where are they located?

Dr. SENCER. About half of the group, about 50, come in and serve 2 years with us, and are assigned to State or local health departments. The other half are located in Atlanta and are responsible for outbreak investigations, assisting the States, and maintaining surveillance of disease.

Mr. EARLY. Where were they a couple years back when Massachusetts had their red tide epidemic? We never had one. We had a head of public health who didn't know what he was doing, who put out the warning. Massachusetts did nothing but suffer by it. Where was a group like that intelligence force to correct that situation?

Dr. SENCER. We respond to the States for the most part, and Massachusetts did not ask for assistance.

Mr. EARLY. So that whole intelligence force only responds to requests?

Dr. SENCER. No. We sometimes stimulate requests and actually we tried—as a matter of fact, sir, I think we actually did have a man assigned to Dr. Fiumara at that time.

Mr. EARLY. That wasn't the man I was referring to.

Dr. SENCER. No, but that was one of the few times we have actually had a person assigned to Massachusetts and there was a Dr. Freeman who was assigned to Dr. Fiumara at that time.

Mr. EARLY. I just see my own State cutting health programs, and under this budget that we have suggested to us they are going to be able to cut without showing that they are cutting, and adequate public health is going to just erode.

Mr. Obey.

OCCUPATIONAL HEALTH STUDIES

Mr. OBEY. Doctor, I think before the buzzer I had asked Dr. Finklea to insert his statement in the record that from now on NIOSH would take the lead role in all occupational studies. Is that a fair characterization of your statement?

Dr. FINKLEA. Yes, in terms of quick response studies to problems.

Mr. OBEY. If that statement was correct, then why do you say in your justification, Dr. Sencer, that Division of Cancer and Birth

Defects is involved in—still back on page 130—in lung cancer among vinyl chloride workers? Why shouldn't that be done by NIOSH?

Dr. SENCER. This again is under the lead of NIOSH, and this is where the work happens to be done. We have a team in the field at the present time under the aegis of NIOSH in Puerto Rico working on a problem of mercury poisoning.

Mr. OBEY. Why the double-up?

Dr. SENCER. Because we have certain talents that NIOSH does not have. We have medical epidemiologists that NIOSH does not have. We were attempting to help them recruit epidemiologists. One of our epidemiologists is now the Director of the Morgantown Laboratory and he has recruited one of our epidemiologic Intelligence Service officials to work with him. We are trying to get several more to assign to Cincinnati.

OCCUPATIONAL CARCINOGENESIS

Mr. OBEY. The final thing you say in this section is that you are looking at angiosarcoma. I understand there are three causes for angiosarcomas as far as we know. One is a drug, one is vinyl chloride, the other is arsenic.

Dr. SENCER. Yes.

Mr. OBEY. Both of which might be present in the everyday environment, but the worst exposure is thought to be the workplace. Did NIOSH begin the project on angiosarcoma?

Dr. SENCER. The problem of angiosarcoma was first pointed up by Goodrich Tire Co. to NIOSH and Dr. Key took the lead in this. Yes, sir.

Mr. OBEY. When you go out and find angiosarcoma, would you tell us how CDC determines if anything in the individual work history might have had something to do with the cancer?

Dr. SENCER. I think this is a question of interviewing the patient or, if this is after the fact, survivors, and attempting to find the work history——

Mr. OBEY. How are those patients interviewed? By whom?

Dr. SENCER. It would depend upon the investigation. It could be by a physician, it could be by a nonphysician epidemiologist, or industrial hygienist.

Mr. OBEY. How often is it done by local health official or county health officer?

Dr. SENCER. Again, I think that would relate to the circumstances. We have developed common history forms that are applicable, and there are quality controls built in, whether it is one of our own physicians. a contractor, or somebody else. There are quality controls that are built in.

Mr. OBEY. In the case of angiosarcomas, how often has the interview been done by a county health officer?

Dr. SENCER. I can't tell you without asking staff.

Mr. OBEY. My impression is that it is pretty prevalent. Dr. Finklea, Dr. Selikoff has indicated to me how complex work histories can be and how easily critical factors can be overlooked. You have to know something about industrial hygiene as well as epidemiology. You have to have a lot of expertise with the particular chemical, and you might still miss a key factor. Do you think local county health officials have the kind of training to be asking those kinds of questions?

Dr. FINKLEA. I think you bring up a very large problem in this country, Congressman. We have minimized the inputs of public health into both the environmental control area and the occupational safety and health area. We would certainly like to see this competency exist in every State.

Mr. OBEY. My question is, do you think right now the average local health official in my district in Wisconsin has the kind of sophistication necessary to really be the kind of person who should be doing the interviewing in cases like this?

Dr. FINKLEA. I think if you did have that in your district it would be very unusual and you would be very fortunate.

Mr. OBEY. Unless my information is totally bad, that is why I wonder why some of the interviewing has in fact been done that way.

Dr. SENCER. We can check but I would imagine rather than local officials these have been State epidemiologists.

Mr. OBEY. I would like to talk to you more about that.

Dr. SENCER. Yes, I will be happy to discuss this subject with you.

HAZARDOUS SUBSTANCES

Mr. OBEY. There are a number of questions I want to put in the record. Let me just for the record begin so we get it laid out. When you are talking about the potential danger faced by a worker in the workplace, how many workplace chemicals do we have standards for right now?

Dr. FINKLEA. We have several hundred consensus standards that involve dust, fibers and chemicals. In addition, we have over 30 recommended standards for the control of chemicals that have been forwarded to the Department of Labor.

Mr. OBEY. Criteria documents have been prepared for how many?

Dr. FINKLEA. I think 30 or 31 have been transmitted, sir.

Mr. OBEY. How many chemicals in the workplace roughly?

Dr. FINKLEA. We would be concerned about 17,000 chemicals. The subset of these we would be most concerned about would be less than a thousand.

Mr. OBEY. So of that thousand how many do you think there are adequately prepared standards available for now?

Dr. FINKLEA. I think that by the time the standards completion program is completed, we will be able to approach several hundred of these, perhaps half of the thousand most common ones, and certainly we will be able to approach all those agents with which we know we have a problem.

Mr. OBEY. About 20 percent of the thousand?

Dr. FINKLEA. If we are to assess or try to look for new problems among these many, many other agents, we do have to apply rapid screening procedures.

Mr. OBEY. How many new chemicals come into the workplace every year?

Dr. FINKLEA. There are several thousand that are developed in laboratories. There are probably 300 chemicals a year produced commercially. If you consider the intermediaries that were involved, it might be more than that.

OCCUPATIONAL HEALTH RESEARCH FUNDING

Mr. OBEY. Your justification for the budget request is $2.4 million below the amount available.

Dr. SENCER. That, counting the cancer pass-through money, yes, sir.

Mr. OBEY. What do you mean? My understanding is if you are counting that cancer pass-through money, isn't it in fact $5 million below?

Dr. SENCER. $4.5 million, yes, sir.

Mr. OBEY. Dr. Finklea, what will the impact be in this cut of funding of research?

Dr. FINKLEA. I think the impact is in two areas: training grants and research. The impact on research would be to slow down the program initiative in occupational cancer and the impact in training, we discussed earlier, would be to essentially phase out the Federal participation in training occupational safety and health professionals.

Mr. EARLY. Would you yield for one question?

Mr. OBEY. Yes.

Mr. EARLY. Are you suggesting those decreases are going to be picked up by the States and local communities? Is there any way you are suggesting that research is also going to be absorbed by some of the States.

Dr. FINKLEA. No, sir, we are not suggesting that. I think we are saying the cancer initiative that was planned will not get off as rapidly as we had hoped.

Mr. OBEY. You say it can be cut back in both areas, and I don't understand the statement on page 6 of your statement, Dr. Sencer:

> The budget will also permit NIOSH to carry out increased research on hazardous substances and harmful physical agents and allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiologic investigations in 40 high-risk industries, as compared with 37 in 1976.

Dr. SENCER. Perhaps the word "increase" is misused.

Mr. OBEY. What you are saying, Dr. Finklea, is that you will have to add around $5 million just to keep things going at the current level?

NIOSH INSTITUTES

Dr. FINKLEA. That is correct.

Mr. OBEY. In addition to maintaining current programs are there any new initiatives which you feel the agency should undertake?

Dr. FINKLEA. There are 6 major areas which we are discussing within the Department and with the American labor movement and the professional groups in this area. I think the first initiative dealt with occupational safety research, and this is primarily at the request and cooperation of the Department of Labor to better evaluate the safety standards which were part of the original consensus standards, and we will be targeting this to try to reduce facilities and permanent disabilities in the safety area.

The other would be in manpower development, and we would like, if it were not possible to work through the training grant mechanism, to work with the people in the Department who are dealing with the health resources effort, especially the Health Manpower Act. The

third would deal with special problems of women in the workplace. As you know, we are employing women in a much greater variety of jobs and these women and their unborn children are encountering hazards, the effects of which have not yet been determined. We think we need an increased effort in occupational respiratory diseases, other than coal workers and pneumoconiosis. We think that the Institute and Department should do a better job in control technology, that is to assess the technological feasibility of recommended standards, to develop better personal protective equipment, and to stimulate research and development in the private sector, and if necessary, within the Federal Government.

We would like to be able to look at the industrial process and by measuring one chemical, get an index as to how well that process is being controlled, rather than have to go on an agent-by-agent basis and measure maybe 100 in that process. So we are trying to develop the materials necessary for a more efficient enforcement in the Department of Labor.

Mr. OBEY. These are all initiatives you have in mind in your 5-year plan?

Dr. FINKLEA. That is correct. One area we also discussed was to improve the health research grant program so we can better utilize scarce clinical specialties, to especially deal with muscle, bone, joint disease, neurological disease, and to work with our sister institutes in chronic kidney disease.

### NIOSH FUNDING PLAN

Mr. OBEY. Would you provide for the record a copy of what the 5-year funding plan has been and list the financial resources which would be necessary each year in order to take the kind of initiatives that you have been talking about?

Dr. FINKLEA. We would be happy to do that.

[The information follows:]

### FIVE YEAR FUNDING PLAN

At the present time, National Institute for Occupational Safety and Health is developing its input into the health strategy of the Department. This material will not be finalized until on or shortly after April 1, 1976, and at that time will be available to provide the resource projections for fiscal year 1978–82. Previous professional judgment, at the time of passage of the act and creation of the Institute, was that about 1,200 positions and approximately $64 million (1970) would be required to meet the purposes of the act.

### FORWARD PLAN

Mr. OBEY. What does the 5-year plan project that we should be spending for occupational safety and health research at the end of the 5-year period.

Dr. FINKLEA. When the Institute was first established the plan within the Department was to see it grow by 1980 to about 1,200 positions and roughly a budget of $60 million. We think that position target is approximately correct. I think with inflation and better definition of some of the problems we are dealing with, it would require perhaps greater funding than that.

Mr. OBEY. How much?

Dr. FINKLEA. We can provide detailed estimates. I would think it would be consistent with the inflationary impact we have seen.

Mr. OBEY. Approximately $100 million.

Dr. FINKLEA. Yes.

Mr. OBEY. So last year you said we were spending about how much per worker in health research?

Dr. FINKLEA. I think with the congressional budget we are operating under now it is about 45 cents per worker.

Mr. OBEY. So what does that lead up to? If you did everything you are suggesting be done, what would you be spending, a dollar per worker?

Dr. FINKLEA. That is correct.

Mr. OBEY. That is not very much. How much do we spend per coal worker?

Dr. FINKLEA. Our expenditures this year are about $24 per coal miner. Of course that is a very hazardous industry.

Mr. OBEY. I am not knocking it, but I am suggesting if you have a steel worker, if you are a chemical worker, you have a long piece to go before you begin to match what is being done in at least 1 or 2 industries.

Dr. FINKLEA. That is correct.

Mr. OBEY. You indicated that OSHA had been in contact with you about safety standards. This committee took actions this year in frustration over the OSHA standards for safety. Many of them an archaic, others are difficult if not impossible to understand. We finally had to direct OSHA to straighten those out. It is your responsibility to assist OSHA in the simplification and improvement of those standards, isn't it?

Dr. FINKLEA. Yes, it is.

Mr. OBEY. How much is being done right now?

Dr. FINKLEA. Right now the Institute is spending about $1 million on safety research. We have recently convened a task force involving people from our Department and from the Department of Labor to tell us what additional efforts need to be done here, how we would have to impact——

Mr. OBEY. How much more will you spend this year as a result of the instruction which this committee gave OSHA to shape up their shop on safety standards?

Dr. FINKLEA. We were hoping to be able to spend a total of $3.7 million with an additional 20 positions this year.

Mr. OBEY. How can you do that if your budget is cut?

Dr. FINKLEA. It will be very difficult to do it.

Mr. OBEY. Like Secretary Mathews you have a capacity for understatement.

Mr. MILLER. I do have to say though, Mr. Obey, we need more perspective on this program. We were looking at $32 million in the 1975 appropriation and $32 million spending level before the veto was overridden, and we had a very restricted ceiling. We provided a $5-million increase at that point and felt we were giving this program a real priority.

Mr. OBEY. All I am trying to do is simply show the budget which we are dealing with is really unrealistic because we have already provided last year more than the agency was willing to ask for in the

previous year because of budget constraints. I think the statistics Dr. Finklea cited earlier show this.

I want to make sure you supply for the record the same chart you supplied last year showing the shortfall in the kinds of professionals we need to do these.

Dr. FINKLEA. Yes, sir.

[The information follows:]

ESTIMATED OCCUPATIONAL SAFETY AND HEALTH MANPOWER DEFICIT

| | Present census | Deficit |
|---|---|---|
| Occupational physicians, board qualified or certified | 500 | 1,200 |
| Industrial physicians, with special short-term training | 2,700 | 4,200 |
| Occupational safety and health professionals | 3,600 | 8,700 |
| Industrial hygienists (certified, ABIH) | (600) | (4,000) |
| 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] | 7,000 | 19,700 |
| OSH technicians [2] | 5,000 | 8,800 |

[1] Includes equally qualified physician assistants.
[2] Includes those working in safety or industrial hygiene who are not now board certified.

EFFECT OF WORK EXPOSURES ON THE UNBORN

Mr. OBEY. Let me ask you about this problem of protecting unborn children of women workers. Most of the attention in the press on worker exposure to dangerous chemicals has been on chemicals that cause cancer. I understand there is an increasing suspicion that many of those same chemicals cause birth defects, cause genetic damage as well in unborn children, their mothers being exposed to those chemicals, and that they might suffer some consequences. More and more women are going into the work force. Can you tell us how many women of childbearing age are in the work force in this country?

Dr. FINKLEA. I think it would be between 35 million and 40 million; roughly, 30 million, I believe.

Mr. OBEY. How many of the chemicals now regulated by OSHA are presently suspect as agents that might cause birth defects and miscarriages?

Dr. FINKLEA. In our toxic susbstance list, we have published what information is available on this, and there are over 20 such agents that have been tested. The majority of chemicals for which we have standards have not been tested in this area.

Mr. OBEY. Roughly, how many women in the work force are exposed to those 20 chemicals?

Dr. FINKLEA. I do not have that information. We are attempting to compile it.

Mr. OBEY. I would like to have it at this point in the record.

Dr. SENCER. NIOSH is putting what they do into the Federal Register to try to get additional information that may not have been published.

[The information follows:]

WOMEN IN THE WORK FORCE EXPOSED TO TOXIC CHEMICALS

There are approximately 16 million women in the labor force between age 16 to 34 which are the prime childbearing years. Of these, there are over 1

million working in occupations where there is potential exposure to chemical substances that might cause birth defects and miscarriages. Some of the substances are anesthetic gases, lead, benzene, and methyl mercury.

EXISTING STANDARDS

Mr. OBEY. Would existing standards protect the unborn?

Dr. FINKLEA. Most of the consensus standards were not established with the view of protecting women of childbearing age in the workplace.

Mr. OBEY. You say they were not?

Dr. FINKLEA. That is correct. With our recommendations that we are making to the Department of Labor, they do address that issue, but the consensus standards established in the past do not consider that question. We are trying to relook at all of these to make sure that we base our recommendations on the information that is available, but frankly, we are not going to have the information for the immediate future.

Mr. OBEY. Most of those chemicals are not regulated at all?

Dr. FINKLEA. They are regulated but not with this in mind.

Mr. OBEY. Why don't you expand for the record on what you propose that the Government do about the problem.

[The information follows:]

RECOMMENDATIONS TO PROTECT WOMEN IN THE WORKPLACE

Because current National Institute for Occupational Safety and Health toxicological and epidemiological studies suggest a relationship between exposure to vinyl chloride, lead, anesthetic gases, and fetal wastage and malformations; and because the number of chemicals in the workplace with similar properties is probably extensive and increasing; the Institute is proposing to give special emphasis to women and the fetus, and male fertility as influenced by the working environment. The National Institute for Occupational Safety and Health will incorporate into its ongoing research programs and in its proposed standards a special emphasis on carcinogenesis (including transplacental carcinogenesis), mutagenesis, and teratogenesis particularly as related to pregnant women and the fetus.

The initial phase of this new initiative will be a better surveillance system to identify problems of hazards and concentrate studies on high-risk industries where the effects of chemicals upon the pregnant woman and the fetus would be greatest. The National Institute for Occupational Safety and Health has already begun discussion with the Equal Employment Opportunity Commission on the scope of the potential problem and its implications regarding equal employment opportunities. Also, it has held discussions with other Federal agencies involved in research on metagenesis, teratogenesis and transplacental carcinogenesis to sensitize the scientific community to the need for a focused attention to the problem. In addition the National Institute for Occupational Safety and Health has assembled representatives of organized labor, management, and others to discuss the complex issues involved and the priority that must be given to this now and in the future.

BIRTH DEFECTS

Dr. SENCER. May I just have one moment on that subject?

Mr. OBEY. Sure.

Dr. SENCER. When we look back at what we know about birth defects and toxic substances, the classic example unfortunately is thalidomide, and none of the tests that were being done at that time would have picked up the fact this would be a teratogen. It was only

through surveillance of what was happening this was picked up. This is one of the important reasons to maintain the birth defects surveillance programs along with looking at chemicals. Frequently the technology we are using to determine whether something causes a harmful effect is not sensitive enough to detect the problem in the laboratory.

Mr. OBEY. I have a number of questions I want to ask you, and about 30 or 40 others to submit for the record. Since we do have a vote, by the time I get back here it will be about 20 after. Why don't we break for lunch and come back at 2 o'clock.

AFTERNOON SESSION

Mr. OBEY. The hearing will come to order. I will continue with the remaining questions I have.

OCCUPATIONAL RESPIRATORY DISEASE PROBLEMS

Last year we talked about the problems of grain dust in grain elevators, and that pertained to problems that some of the workers had had in the Duluth-Superior area in my district and in neighboring Minnesota. What has NIOSH done with regard to that grain dust problem?

Dr. FINKLEA. I think there are several positive actions we have taken. First, we have had an industrial hygiene survey of these facilities. We are in the process of awarding a research contract to look at the specific problems of bronchitis and grain handlers' asthma in this situation. We have also been quite active in our recommendations to the Department of Labor and our research on a number of other occupational respiratory disease problems.

Mr. OBEY. As you indicated, you planned to do a special program in the area of respiratory diseases. Are you going to be able to do everything that you had contemplated within the constraints of the budget you are presenting today?

Mr. FINKLEA. I think we will be able to do the study on grain dust that you referred to earlier.

Mr. OBEY. What about the other respiratory areas?

Dr. FINKLEA. We have a very active program in pneumoconeosis. We will not be able to do all we would like in a number of other respiratory disease areas.

Mr. OBEY. One thing you mentioned earlier which I do not understand. You mentioned the Institute should be addressing the question of control technology. Why isn't that an OSHA responsibility?

Dr. FINKLEA. I think OSHA does have the responsibility of assessing the economic cost of controls. The National Institutes for Occupational Safety and Health have the responsibility of assessing the technological feasibility of controls, that is the state of the art of control technology that you might take from one industrial process and apply it to another. Also we have the responsibility for assuring that you can monitor an industrial process to see whether it is working right; make sure it is not exposing workers. And we have the responsibility for control technology and developing the personal protective devices that are necessary if it is impossible to retrofit an industrial process with control technology.

RESEARCH GRANTS

Mr. OBEY. What about the research grant program? Under the President's budget there is no expansion of that program. What are the kinds of things that your 5-year program envisions you doing in this area?

Dr. FINKLEA. We think the research grant mechanism would be most appropriate to bring a number of medical specialists from universities into the area of occupational safety and health. Working together with parts of NIH that would be interested, we would like to see this concentrate on problems of muscles, bones, and joints, particularly back problems. We are very concerned about etiologic factors in chronic renal disease in the workplace. We also would be concerned that we could get a better research capability in the university for the occupational dermatoses, the skin disorders in the workplace.

Mr. OBEY. How much of that are you able to do under this budget?

Dr. FINKLEA. We have a grant program here that we try to work with in cooperation with the other National Institutes of Health, but we are not able to cover all these areas at this time.

NIOSH RECRUITMENT

Mr. OBEY. What is the policy with regard to the clearance of personnel selections in CDC and in any hospital?

Dr. FINKLEA. In general a supervisor will talk over with his supervisor his choice of immediate subordinates. We have a pro forma clearance mechanism that involves personnel clearance, all personnel GS–13 and above. In the Institute we have a requirement that all commissioned officers of O–4 rank or above be approved by the Institute doctor.

Mr. OBEY. Would you repeat that again? You said every body GS–13 or above.

Dr. FINKLEA. There is pro forma clearance at the agency level; that is correct.

Mr. OBEY. But they are approved by CDC?

Dr. FINKLEA. At the agency level, that is correct. I said the commissioned officers at O–4 and above are approved at the Institute level. That is an additional requirement. In addition, it is customary for the Institute or Bureau Directors to talk over their choices of chief subordinates with their superiors. My division directors talk over their choice of branch chiefs.

Mr. OBEY. How many people are we talking about?

Dr. FINKLEA. We are probably talking about 150 or 160 civil servants, maybe 100 commissioned officers; across the Center as a whole we are talking about 500, since this is a centerwide policy, nothing specific for NIOSH.

CRITERIA DOCUMENTS

Mr. OBEY. NIOSH has been criticized in its research effort by some people who suggest that it is not sufficiently supportive of or focused upon the documentation of criteria for support of recommended standards. What is your response to that?

Dr. FINKLEA. We recently did an analysis of this after talking with some of the oversight committees and others. Our intramural program,

about 61 percent, has been directly related to criteria documents in direct support of it. Of the intermural program, the same percentage would hold, with perhaps the toxicology program being an exception. This program over the years has more addressed the needs of the so-called consensus standards, the threshhold limit standards of the past. We have redirected this toxicology program at the present time.

Mr. OBEY. There has also been some criticism of unnecessary paperwork, publishing, et cetera, by NIOSH. Does NIOSH make the results of its contract research available to academic people, to industrial, consumer groups who might benefit from it?

Dr. FRANKLIN.

Dr. FINKLEA. Yes. We have several demonstration strategies.

Mr. OBEY. What kind of procedures?

Dr. FINKLEA. First of all, we do encourage our investigators, contractors, and grantees to publish their findings in the scientific literature and present them before technical groups. That is the mainstay for the more important findings. We also try to assure that at least the abstracts of every contract report are placed in the information base that the Institute maintains. A listing of abstracts is made available to researchers. We take our contract reports and make them available either through the Government Printing Office or through the National Technical Information Service so that those people who need them can request them.

Mr. OBEY. What about GPO? There have been stories about GPO destroying copies of many of your reports.

Dr. FINKLEA. I was never notified that GPO was disposing of any copies of our reports. There has been some difficulty in getting good, quick service for our reports from GPO. Requesters of these reports have told us of this. We have instituted an evaluation contract. We are trying to work with them to assure we have a better distribution of these documents in the future. Right now GPO has about a 1-year level of documents. We have a shortage of certain key documents in our health and safety guides and the criteria documents.

Mr. OBEY. How extensive is your list of publications?

Dr. FINKLEA. I think we have about 100 publications that should be kept in stock by GPO. We have reports on each of our health hazard evaluations listed with National Technical Information Service and also listed in journals each month. These run about 70 per year.

Mr. OBEY. How do you determine how many should be printed on the initial printing? How have your orders been in comparison?

Dr. FINKLEA. We have had some disagreement with GPO about the number of documents that might be needed in that area. We hope to straighten out this difficulty in the future. In our evaluation contract we have established a procedure whereby we and GPO can get together on the number of documents that will be ordered.

Mr. OBEY. You don't have your own public relations operation; you rely on CDC to publicize your publications. Is that right?

Dr. FINKLEA. The public information function is at the agency level; we have had a list of publications circulated to the technical community. In addition, the agency has authorized the establishment of a public information officer for NIOSH under the reorganization.

OCCUPATIONAL RESPIRATORY DISEASE PROBLEMS

Mr. OBEY. Let me go back to the grain dust question again. When is the last time that NIOSH has been involved with anything in the Duluth-Superior area?

Dr. FINKLEA. I think Dr. Merchant has been in contact with Dr. Rankin of the University of Wisconsin. It is my understanding about a month ago, about developing a research proposal there, but I have not been in contact with him since that time.

Mr. OBEY. It is my understanding that the grain dust has been regulated under a nuisance standard. Is that correct?

Dr. FINKLEA. That is correct, yes.

Mr. OBEY. That is all the questions I have for now. I will submit the others.

Mr. FLOOD. Mr. Conte.

STATES HAVING CAPABILITY OF PERFORMING BLOOD LEAD ANALYSIS

Mr. CONTE. Last year you provided for the record a list of 35 States and territories that had the capability of performing blood lead analysis. How many do this year?

Dr. SENCER. There are now 43 States with laboratories that have the capability to perfrom blood lead analysis. The seven States that do not have this capability are Alaska, Arizona, Colorado, Mississippi, Rhode Island, South Dakota, and Vermont.

CHILDREN SCREENED FOR EXCESS LEAD

Mr. CONTE. In your opening statement I noted that 440,000 children were tested for excess lead and 28,000 were found to have excess lead. In the justification your estimation for next year is 250,000 and 20,000, respectively. Why the reduction in those screened and to what is the reduction in excess lead attributable?

Dr. SENCER. The level of screening in fiscal year 1977 is related to the reduced amount of funds requested to support project grants. The reference to 250,000 is the estimated number of children who will be screened for excess lead by federally funded projects during fiscal year 1977. This level of screening will identify 20,000 children with undue lead absorption. This reduction will be offset by the expected screening of 450,000 children through other locally and federally funded child oriented health programs such as EPSDT.

EPSDT PROGRAM

Mr. CONTE. How much, if any, overlap is there between the EPDST program, the material and child health program, and projects funded through preventive health services?

Dr. SENCER. MCH and EPSDT programs provide medical care sevices, including preventive health services, to specific groups of people. Preventive health services grants are directed toward specific disease problems as they exist throughout the population, and provide for the most part the outreach types of activities that are needed to identify people who are in need of preventive services and insure that they are received. The actual delivery of such preventive services as screening

tests or immunizations may be delivered through or financed by other federally assisted programs such as MCH or EPSDT if the individual receiving them is eligible. The type of coordination needed to insure that health department immunization programs, for example, are complementary to and not duplicative of EPSDT or MCH programs, is achieved at the local level and is facilitated when the health department is responsible for both programs.

I might add that, in the case of lead screening, the EPSDT program, where is has been fully implemented on a statewide basis, has been instrumental in pinpointing communities where lead poisoning exists. This permits the State or local health agency to set up active community screening programs for lead poisoning to identify all children—not just those eligible for EPSDT services—who may have a lead problem.

GENITAL HERPES

Mr. CONTE. I asked you about genital herpes, a sexually transmitted viral disease. Not much was known about it then. What has been learned or done about this since last year?

Dr. SENCER. Since last year, we have been able to better estimate the magnitude of the herpes infection problem in the United States. In a national survey, sampling 1 in every 5,000 office-based physicians, approximately 1 office visit for genital herpes infection was reported for every 10 visits for gonorrhea. This ratio of cases in very similar to that observed among patients in public venereal disease clinics. To further define the trend of herpes infections in public clinics, monitoring clinics have been established to systematically record herpes-related visits. Although this monitoring has begun, trend data will not be available for at least another year. Unfortunately, despite vigorous research supported by NIH, no major breakthroughs have occurred in the treatment or prevention of this sexually transmitted disease. Our emphasis continues to be placed on defining the magnitude of the problem, assessing the accuracy of currently available diagnostic techniques, and developing disease control strategies.

CHILDREN WITH UNDUE LEAD ABSORPTION

Mr. CONTE. How many of the children with undue lead absorption are returned to environments which are high risk as far as lead is concerned?

Dr. SENCER. In the majority of cases, the projects have been successful in locating the probable lead hazard and taking immediate action to remove the hazard from the environment of the child.

With the present technology, lead hazards are found in about 70 percent of the houses inspected. In the others, no hazard is identified; however, these residences generally are occupied by children at lower risk. During fiscal year 1975, 17,600 units were inspected and found to contain a lead hazard. Of these, 10,500 hazards were permanently abated; in most of the others, the hazards were significantly reduced.

PORTABLE LEAD ANALYZERS

Mr. CONTE. Have more sensitive portable lead analyzers been developed and implemented?

Dr. SENCER. DHUD has provided funds for the development of more sensitive portable lead analyzers. Two new portable lead analyzers have been developed, and it is expected that they will be commercially available in June.

LABORATORY IMPROVEMENT POSITIONS

Mr. CONTE. I notice on the table on page 116 an increase of 49 positions for laboratory improvement. What types of positions are these and how do they relate to improvement of laboratories?

Dr. SENCER. The 49 new positions for laboratory improvement include 1 GS–15 hematologist, 2 GS–14 chemists, 1 GS–14 public health advisor, 1 GS–13 education specialist, 1 GS–13 public health analyst, 1 G–12 microbiologist, 1 GS–12 chemist, 2 GS–11 mathematical statisticians, 2 GS–11 microbiologists, 11 GS–9 medical technologists, 4 GS–7 microbiologists, 2 GS–7 cytology technologists, 1 GS–7 histology technologists, 3 GS–5 chemists, 3 GS–5 medical technologists, 5 GS–5 laboratory technicians, 4 GS–5 microbiologists, 2 GS–5 secretaries, and 2 GS–3 clerk-typists.

The increased positions earmarked for Laboratory Improvement Activities for fiscal year 1977 will provide for upgrading the Center's resources to carry out responsibilities under the agreement with the Social Security Administration and Health Services Administration for applying a single uniform set of standards in a consistent manner to all federally monitored laboratories. This includes increasing the number of laboratories directly inspected by CDC examiners under the monitoring portion of the agreement from 900 to 1,400 per year; increasing number of laboratories covered by direct proficiency testing from 2,600 to 3,200 per year; and provide for technical and management consultation to all State health departments in developing their laboratory improvement activities.

STATE AND LOCAL ASSISTANCE IN THE VENERAL DISEASE PROGRAM

Mr. CONTE. What is the current level of State and local assistance in the venereal disease delivery programs?

Dr. SENCER. It is estimated that some $20 million is expended annually by State and local health agencies for venereal disease delivery programs.

HIGH RISK POPULATION SCREENING

Mr. CONTE. How effective have your high-risk population screening contact referral programs been in the venereal disease area?

Dr. SENCER. As a result of targeting gonorrhea screening programs to high-risk populations in 1975, more than 8 million culture tests were obtained from women, of which 4.2 percent were positive for gonorrhea. Of those positive about 346,000 were treated.

With respect to contact referral, more than 300,000 gonorrhea patients were interviewed, resulting in 80,000 new cases of gonorrhea being diagnosed and treated and an additional 90,000 persons receiving epidemiologic treatment for disease.

RUBELLA AND MEASLES

Mr. CONTE. How do you explain the recent rise in rubella and measles?

Dr. SENCER. Both rubella and measles are cyclical diseases. Historically there were epidemic years in which large numbers of cases occurred. As a result, much of the population became immune, and epidemics did not occur again until a large number of susceptibles entered the population. Vaccines have drastically reduced the size of the epidemics, but not enough susceptibles have been vaccinated to completely eliminate the disease; both are still subject to yearly variations.

For example, in calendar year 1975, 16,343 cases of rubella were reported. This total represents a 51-percent decrease from the average number of cases (33,373) for the 5 preceding years (1970–74) and a 66-percent decrease from the average of 47,744 cases for 1966–68, the 3 years immediately preceding licensure and widespread use of rubella vaccines. The 1975 total is 37 percent more than the 11,845 cases recorded for 1974, the record low year, and probably is a reflection of the cyclical nature of the disease.

In calendar year 1975, 24,199 cases of measles were reported. Although this is about a 10-percent increase over the 22,000 cases reported in 1974, it is a 40-percent decrease from the average number (40,740) of cases reported in the 5-year period 1970–74.

Most of the increased cases in 1975 were in outbreaks in children 10 to 13 years of age who were not vaccinated in the mass programs held during 1968, 1969, and 1970, and in significant pockets of susceptibles where immunization levels are about 56 percent. Measles is highly infectious and extremely high immunization levels—in excess of 90 percent—appear to be necesary to prevent outbreaks. Despite gradually improving immunization levels, that level of protection has not been reached in most areas of the Nation.

SMOKING PROGRAM

Mr. CONTE. How much of the Health Education request is for the smoking program?

Dr. SENCER. Based upon the 1975–76 level and with no increase in positions, one-third or approximately $1 million of the health education request will be required to operate the National Clearinghouse for Smoking and Health. In addition, fiscal year 1975 funds in the amount of $1,284,053 currently support 21 health education contracts which contain substantial smoking program components.

NIOSH HIGH PRIORITY AREAS

Mr. CONTE. In your justification on page 137 you state that specific efforts will be directed toward the National Institute for Occupational Safety and Health priority areas. Can you tell us what these areas are and what specific efforts will be made?

Dr. FINKLEA. The National Institute for Occupational Safety and Health research grants will be used to complement the research in our high priority areas. These areas are occupational carcinogenesis, behavioral and motivational factors, injury prevention, and development of criteria for recommended standards. Specific substances which are planned to have criteria for recommeded standards developed in fiscal year 1977 include organophosphorous compounds, tetra alkyl lead, hydrocarbons, etc. Also, some areas to be identified for fiscal year 1978 research and beyond will be assigned to be done through the research grants mechanism.

### TUBERCULOSIS CONTROL PROGRAMS

Mr. CONTE. How do you feel more effective tuberculosis control programs can be implemented?

Dr. SENCER. The technology exists to control and substantially reduce the cases of tuberculosis. This technology is not uniformly applied in all States and local areas. If it were, there would be a more rapid rate of decline in cases of tuberculosis. To achieve this, sufficient resources must be directed to the areas with the greatest problems. The center is attempting to implement appropriate techniques on a nationwide basis by providing technical assistance, consultation, and training for health workers. It is hoped that this will result in the States giving sufficient priority to tuberculosis prevention and control programs to achieve a more rapid decline in the case of tuberculosis.

### IMMUNIZATION ACTION MONTH

Mr. CONTE. How successful was your "Immunization Action Month" this year?

Dr. SENCER. As you know, the immunization action month campaign is a year-long cooperative effort which culminates in an intensive public awareness promotion in October. In addition to motivating parents to see that their children receive the recommended immunization, IAM encourages physicians to monitor their patients' immunization records and to correct any deficiencies. This past year, over 1½ million immunization audit records were distributed to private physicians for attachment to their patients' chart folders. These audit records make it easy for the physician to review in a glance his patient's immunization status, and to order any necessary immunizations during the same visit.

Complete data from the 1975 U.S. Immunization Survey, conducted last September, are not yet available. However, we do know from the Survey that the immunization levels of preschool children are rising for polio, DPT, measles, and rubella, taking the Nation as a whole. In fact, since 1973, national immunization levels among children between 1 and 4 years of age have gone up 4.4 percent for polio, 2.6 percent for DPT, 4.3 percent for measles, and 6.3 percent for rubella. We think that the increased awareness of parents and doctors brought about through IAM has contributed to this improvement. This year's Immunization Action effort is being organized in cooperation with the "Every Child in 1976" Bicentennial project.

SURVEILLANCE REPORTS

Mr. CONTE. I see that surveillance reports for 30 diseases were issued in 1975 with an approximate average circulation of 5,000 for each report: How helpful are these reports in relation to their cost and circulation?

Dr. SENCER. The Center for Disease Control's surveillance reports (24 different subjects) provide an essential national analysis and feedback of selected disease occurrence to State and local health departments. In most instances these reports comprise the only national analysis and summary regularly published and available. By early recognition of national disease trends and provision of appropriate recommendations and guidelines for prevention and control, these reports keep health departments regularly informed. Moreover, by such publications, the need for and the worth of disease reporting is constantly reinforced resulting in improved reporting to the Center for Disease Control. The Center for Disease Control estimates that surveillence reports cost approximately $100,000 a year to edit, print, distribute, and so forth.

SWINE FLU

Mr. SHRIVER. Dr. Sencer, I assume your center has become involved with the detection of the so-called swine flu virus infection at Fort Dix, N.J. in recent weeks. According to news reports, this is the virus which killed millions of people at the time of World War I. What is the situation? What control methods are being undertaken?

Dr. SENCER. The United States Army has conducted an extensive investigation of A/Swine-like influenza at Fort Dix N.J. A total of 12 confirmed cases, 5 by virus isolation and 7 by serologic titer rise with dates of onset of illness between January 10 and February 4, have been reported. Elevated HI titers were found in 273 of 1,321 (21 percent) single specimens tested. Positive titers were found in up to 47 percent of those in a platoon with confirmed cases; rates were as low as 7 percent in platoons without a confirmed case. Preliminary data suggests that the virus was introduced into the post at the reception center during the second week of January, and attempts are being made to trace the source of the epidemic prior to the introduction at Fort Dix. Although one recruit with A/Swine-like influenza pneumonia died, the Army data suggest that the influenza due to A/Swine-like virus may be a milder illness than that with A/Victoria influenza virus.

The Bureau of Biologics, Food and Drug Administration, and Center for Disease Control are holding weekly meetings at which data on A/Swine-like influenza is reported, and at which decisions on which influenza strain will be incorporated into this year's vaccine are reviewed.

DISEASE CONTROL PROJECT GRANTS

Mr. SHRIVER. What will be the effects specifically of the proposed cut of $7.7 million in Federal support for disease control project grants? I don't mean just the number of projects cut, but what types of projects?

Dr. SENCER. The $7.7 million would have been available to support urban rat control programs. These funds support projects that conduct comprehensive rat control programs in deteriorating inner city neighborhoods. The objective of these programs is to reduce the rate population by achieving a general improvement in the residents' living environment through improved services, code enforcement, and education of the community residents. With the reduced funding, we will continue to support, at reduced levels, 45 to 50 of the estimated 70 community projects to be funded in fiscal year 1976. Because of reductions in rat infestations and contributing conditions already achieved, most of the communities which do not receive continued funding should be able to support ongoing activities with local funds.

OCCUPATIONAL HEALTH TRAINING GRANTS

Mr. SHRIVER. What is the rationale for the proposed elimination of the occupational health training grants? Are these adequate personnel in this area?

Dr. SENCER. The basic original intent of the training grant program was to stimulate the development of curriculums and training programs in the area of occupational safety and health. At this time there are not adequate personnel in this area but we feel that many of these curriculums will continue as a result of the logical system of supply and demand through the free market. In addition, we are continuing to work with other manpower programs throughout the Department. Although we cannot assume that there will not be transition problems, every effort will be made to continually improve the overall manpower system.

PERSONNEL COMPENSATION

Mr. SHRIVER. You project a cut in your personnel of about 100 positions, yet your request for personnel compensation is up $1.2 million. Is that all pay raise?

Dr. SENCER. The request includes a decrease of 150 in the number of personnel we will provide, upon request, to State and local health departments to assist in the conduct of disease control grant program. This decrease is offset by an increase of 49 positions associated with the laboratory improvements program expansion and by mandatory increases, such as annualization of new positions funded for part of year in 1975, within grade increases, and pay increases.

LEAD-BASED PAINT POISONING SCREENING

Mr. SHRIVER. The lead-based paint poisoning program is under your jurisdiction. It seems to me that we have been talking about these screening programs for years. What is being done about prevention? Are Federal funds involved in prevention efforts?

Mr. SENCER. This program which is federally funded is a prevention effort. It is aimed at preventing children at the highest risk from suffering the serious sequelae of lead poisoning. This is accomplished through screening, proper medical management, lead hazard reduction, and educational activities aimed at parents and the community. In essence, our approach is directed at preventing illness and death from lead poisoning in children.

NEW AUTHORIZING LEGISLATION

Mr. SHRIVER. What is the status of new authorizing legislation for the disease control project grants?

Dr. SENCER. Amendments to the communicable disease and venereal disease control authorities under sections 317 and 318 of the PHS Act, which expired June 30, 1975, are presently before Congress in the form of several bills. The Senate Labor and Public Welfare Subcommittee on Health held hearings during May on S. 1466 introduced by Senator Kennedy which would extend communicable disease authority under section 317; S. 1454, introduced by Senator Javits, which would extend veneral disease control authority under section 318; and S. 1756 introduced by Senators Schweiker and Javits for the administration, which would combine and extend sections 317 and 318 into a single authority, renumbered as section 315. The Senate committee reported a marked up version of S. 1466 on July 24 in Senate Report 94–330. This bill included the original S. 1466 as title I covering disease control, S. 1454 as title II covering venereal disease, and separate titles covering health education and promotion which was originally S. 1521 introduced by Senator Javits and dental health which was originally S. 2026 introduced by Senator Magnuson. The Senate passed S. 1466 on July 30.

The House Interstate and Foreign Commerce Subcommittee on Health and the Environment held hearings in November 1975 on H.R. 7050 introduced by Messrs. Staggers and Devine, the companion bill of S. 1756; and H.R. 8278, introduced by Mr. Rogers, which would revise and extend sections 317 and 318 and include health education and promotion. No action has been taken on H.R. 6840 introduced by Mr. Rodino, which is the companion bill of S. 1454. The Senate–passed S. 1466 is also pending before the committee.

Bill No. S. 1466 passed by the Senate did not include authority for the lead-based paint program. Instead, the committee reported S. 1664, introduced by Senator Kennedy on July 16 after holding hearings on June 16. This bill would extend authority under the Lead-Based Paint Poisoning Prevention Act through fiscal year 1978. It would amend the present authority to require intense followup to insure that identified cases are protected against further exposure, prohibit use of lead-based paint on cooking utensils, toys, furniture, and federally assisted residential structures, and redefine the allowable percentage of lead. The Senate passed S. 1664 on February 19, 1976. The House held hearings on H.R. 4444, introduced by Mr. Rangel, in November 1975, but no further action has been taken on this bill.

OTHER FEDERAL GOVERNMENT AGENCIES INVOLVED IN OCCUPATIONAL HEALTH

Mr. SCHRIVER. Could you tell me how many agencies or divisions of the Federal Government are now involved in any way in the occupational health field? You might put a breakdown of that in the record, including approximate expenditures by agency.

Dr. FINKLEA. This is a difficult question to answer. For example, many Federal agencies support research in medicine, toxicology, environmental measurements and control, safety, and other areas pertinent to worker protection, which, although conducted under their authorities primarily for other purposes, have direct application to

occupational health. In addition, most Federal agencies conduct safety and health programs for their own employees which could be considered; and, of course, we have the enforcement programs of Occupational Safety and Health Administration and Mining Enforcement and Safety Administration which represent a significant Federal input into occupational health. However, if we limit our consideration to Federal agencies carrying out health research involving worker population and/or the effects and control of hazardous agents found in the workplace then, I believe the following agencies in addition to the National Institute for Occupational Safety and Health—Center for Disease Control could be considered to have major involvement: National Cancer Institute; National Heart and Lung Institute; National Institute of Environmental Health Services; National Institute on Alcohol Abuse and Alcoholism; Mining Enforcement and Safety Administration; Energy Research and Development Administration; Environmental Protection Agency; and Social Security Administration.

Unfortunately, we cannot give an accurate breakdown of expenditures at this time. This would have to be done on a project-by-project basis. However, I would like to point out that we are in the process of obtaining information on the number of occupational health studies which these and other agencies are supporting to include in our occupational safety and health clearinghouse function. In the near future, we should be able to give you a good estimate of total expenditures. In fiscal year 1976, National Institute for Occupational Safety and Health will expend approximately $44.5 million. Even if we estimate that these other agencies are, in total, expending a comparable sum, the Nation is spending something less than a dollar per year per worker for occupational health research.

### COOPERATION WITH AGRICULTURAL EXTENSION SERVICES

Mr. SHRIVER. You mention that you work with Agricultural Extension Services in certain projects. Tell us more about that.

Dr. SENCER. One of the center's major health educatior demonstration projects is with the Arkansas Cooperative Extension Service. This project is designed to utilize the standards extension service approach to community development and group process to determine how effective this delivery system can be in changing health attitudes and health behavior or rural populations. Although the project is statewide in scope, efforts are concentrated in 15 selected counties which are working on specific health education projects directly under the county agricultural agent and home economist. The professional health education staff of the project provides advice, guidance, and professional subject matter assistance to the county staffs.

In two counties these staffs are working with 4H and other youth groups in advising the local farmers in the correct use of pesticides and the disposal of the residue and containers. In two other counties, work-study programs have been designed to teach youth groups about the health care system in the local area. These groups will then serve as resource workers in disseminating this information throughout the communities. In other counties, indigenous health education aides have been assigned to work with selected families in their communities over a 6-month period of time. Other projects are in hypertension education and health decisionmaking.

Each county has a planning committee composed of local lay people and professionals. These committees provide active program planning and guidance to the community by bringing together interested organizations and health providers as resources to community-based activity around the catalyst—the country agent or home economist.

If successful, the health education delivery system demonstrated in this project may be adapted for replication in other States.

DESK REFERENCE

Mr. SHRIVER. What is a "desk reference?" You mention one in your statement in the area of smoking and health.

Dr. SENCER. The desk reference on smoking and health is one volume consisting of 12 selected chapters from annual reports to Congress since 1971 which present the known health hazards from smoking. These chapters present summations of the scientific information on the relationships between smoking and cardiovascular disease, cancer, chronic obstructive bronchopulmonary disease, pregnancy, peptic ulcer disease, allergy, tobacco amblyopia, and involuntary smoking or effects to the nonsmoker. This reference edition was prepared to provide the individual ready access to the principal information on smoking and its effect on health.

COOPERATION WITH AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. SHRIVER. Does your Center work with the Agency for International Development in the area of worldwide health problems? Tell us about that.

Dr. SENCER. The Center for Disease Control has, over the years worked closely with the Agency for International Development. This cooperation has been both through technical assistance mechanisms, through areawide programs, through support and consultation to the United States efforts in the global malaria eradication campaign, and through bilateral agreements between the United States and individual nations. The Center has had major long-term projects with the Agency for International Development in smallpox eradication, development of cholera vaccines and treatment methods, evaluation of family planning programs, evaluation of malaria programs, laboratory and field testing of insecticides, and nutrition surveys. The Center has also had many ad hoc projects with the Agency for International Development, such as training programs for foreign nationals, consultations with health authorities in developing nations, and disaster relief.

The Center, through a formal agreement, is currently monitoring the quality of insecticides procured by the Agency for International Development for use in malaria programs, continuing to provide short-term field consultation for evaluation of overseas malaria programs. Consultation and technical assistance is also being provided to family planning programs in many of the developing nations.

NIOSH WORK PRIORITY

Mr. OBEY. What factors determine the priority given to individual substances in developing criteria documents?

Dr. SENCER. The number of workers exposed; the potential severity of the problem; whether the substance is a possible carcinogen, mutagen, or teratogen; the lack of an existing OSHA standard; and new information indicating health effects not previously recognized.

Mr. OBEY. What weight is given each factor?

Dr. SENCER. The factors are not weighted in an analytical sense, they are combined and balanced through professional judgment to arrive at a final priority ranking. Under the old priority system the number of workers exposed and severity had equal weight.

Mr. OBEY. How do the 1,500 suspect carcinogens impact priority formulation and on what basis are they integrated into the overall priority list?

Dr. SENCER. Carcinogenicity is one of the five factors considered in the priority list. At the same time we are setting priorities for full criteria documentation, we are also initiating a project to develop recommended standards for carcinogenisis, mutagenists and teratogenisis which would deal with specific issues as opposed to the full criteria approach. We see the output of this project, being similar to the work done on the 14 carcinogens several years ago, wherein we analyze and document research information as it relates to the hazard of concern, that is, develop a recommended standard based on the carcinogenicity of the hazard. We anticipate that through this procedure we can handle a large number of substances on a yearly basis as opposed to the full criteria document route. Also, this will allow us the flexibility to handle emergency situations as they arise.

Mr. OBEY. What data are needed to update the priority list and how is NIOSH accumulating the data?

Dr. SENCER. A better estimate of the number of workers exposed or distribution of hazards throughout industry would be most helpful. We are finalizing the results of the national occupational hazards survey which should give us better data; also, the expansion of the registry of toxic effects of chemical substances to include human toxicity data and results of epidemiological studies should give better data. This is now in the developmental stage. Other information such as the quantity of chemicals produced and their distribution throughout industry would be most useful.

### NIOSH, OSHA COORDINATION

Mr. OBEY. To what extent are NIOSH and OSHA coordinating the priorities associated with criteria document formulation?

Dr. SENCER. We have had a number of meetings with the staff of OSHA's Office of Standards who are working on their program to develop priorities. The Director of the Division of Criteria Documentation and Standards Development of NIOSH, also serves as a liaison to OSHA's contract with Stanford Research Institute and is aware of their efforts. OSHA has provided us with some preliminary recommendations concerning priorities; however, as we indicated to them at that time, their input was too late to affect selection of criteria documents under our current conractual arrangements. We have, however, indicated an intent to have their input to our priority development activity and look at such recommendations as a major resource.

Mr. OBEY. Does NIOSH plan to follow the priority system being

developed for OSHA by SRI? If so, how will the economic factor to be considered in the priority system affect the mandate of NIOSH?

Dr. SENCER. We made a commitment to work with OSHA to the extent of assigning a liaison person; however, it remains to be seen if their system, when developed, will be realistic for use by NIOSH. It is our understanding that the "economic factor" is really the cost to the agency to develop a standard—not including any needed research—as opposed to any question of economic impact. If this is the case, we must assume that there would be different cost factors for NIOSH in developing recommended standards and OSHA in promulgating final standards.

Mr. OBEY. Since most of the criteria documents scheduled for completion in 1978 have been selected, how soon will the coordination with OSHA impact NIOSH criteria documents, research, et cetera?

Dr. SENCER. Late fiscal year 1978 or more realistically beginning in fiscal year 1979.

SURVEILLANCE ACTIVITIES

Mr. OBEY. What procedures have been established to insure coordination between surveillance and these other activities?

Dr. SENCER. Under the recently approved reorganization of the Institute, the surveillance activity is made a part of the Division of Surveillance, Hazard Evaluations and Field Studies, which includes industrywide field studies and health hazard investigations. This will promote the interfacing of these activities in a fashion that will result in a coordinated and mutually supportive effort.

Mr. OBEY. What criteria are used in selecting surveillance projects; specifically, illness, and injury surveillance?

Dr. SENCER. Projects relating to injury and illness surveillance are keyed to the continuous assessment of the magnitude and extent of occupational injury using new and existing data from sources such as Federal, State and local agencies, of such data sources has been an important strategy, that is, mortality and morbidity rates for specific conditions for a variety of occupational groups. Because of the recent emphasis on occupational cancer, specialized data sources relating cancer to occupation have been found and utilized to draw inferences on associations between specific occupations and cancer (that is, Roswell Park Memorial Institute hospital records and Johns Hopkins University multiple cancer case series). Surveillance projects also are keyed to improving existing data sources and developing new ones.

OCCUPATIONAL HAZARD SURVEY

Mr. OBEY. What are your plans for completion and what use will be made of the NOHS data?

Dr. SENCER. The National Occupational Hazard Survey (NOHS) is scheduled for completion by June 1976 with a possible slight carryover into July. Shortly thereafter (approximately September) volumes II and III will be published. Volume I, which has been published, describes the method by which the survey data were obtained. Volume II will be in narrative form explaining the various aspects of the survey, going into detail on the data processing, statistical, and chemical industrial hygiene problems involved. Volume III will be a compilation of summary tables, approximately 1,200 pages in length.

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Specifically, the task that remains in NOHS is a finalization of the statistical procedure for projecting national statistics from the sample. A data base management system has been provided, and the 2½ million data records will be added into the data base management system for efficient retrieval for summary tables and future requests. For some period of time, approximately 6 months to a year after "completion," it will be necessary to update the NOHS data base with information received from manufacturers on trade name products. It has not been possible to require that manufacturers respond within a specific time frame and, therefore, there are many outstanding requests for information that must be processed and added to the NOHS data. As a point of information, before the trade name data are added to the system, a generalized formula will be used in its place.

The NOHS data will be used by NIOSH for priority setting. It will undoubtedly be used by NIOSH's Division of Surveillance, Hazard Evaluations and Field Studies as a primary information point in its industrywide studies programs and related activities and by the Division of Criteria Documentation and Standards Development. Both the Occupational Safety and Health Administration and the Environmental Protection Agency have expressed their desires for information from NOHS as soon as possible. Innumerable requests from various sources have been received for our data.

Mr. OBEY. What are your plans for accumulating data from the individual States or other sources which might be used to update the hazard survey?

Dr. SENCER. The National Surveillance Network, which is a State-participating system, will be looked at closely in the near future to determine its feasibility as a separate system or its potential for being used as an update mechanism for NOHS. In a recent discussion with OSHA personnel, some interest was expressed in the data that NIOSH currently has and whether or not we will be pursuing this activity. So far, these discussions indicate the potential for interagency activity between OSHA and NIOSH.

Several State and local occupational health agenceis have been contracted by NIOSH requesting access to industrial hygiene, hazard and general occupational health data. Where appropriate, these data are being microfilmed and compiled by NIOSH for abstracting, summarizing, etc. for use in the NIOSH surveillance system.

Mr. OBEY. What procedures does NIOSH use to collect data and evaluate the potential hazard of new substances which are introduced yearly into the workplace?

Dr. SENCER. At this time information on a new potential hazard is obtained primarily through health hazard evaluations, individual communications, and utilization of general information resources such as the NIOSHTIC system and the Registry of Toxic Effects of Chemical Substances. Although NIOSH's information resources are updated monthly with information from more than 400 journals, it is not usually possible to know which of these are truly "new substances" in the workplace.

Recently the Registry of Toxic Effects of Chemical Substances has been growing at a rate of approximately 4,000 substances per year. This is not to say that there are 4,000 new substances in the workplace. However, it is the number of substances that NIOSH would need to

investigate yearly to evaluate potential hazards which may be newly introduced into the workplace based only on our current means of data collection. Clearly, NIOSH is not large enough to evaluate each of these substances, but may receive additional support through passages of the toxic substance legislation.

Mr. OBEY. How will new substances be incorporated in the NIOSH priority system now being devised?

Dr. SENCER. Substances will be recommended by our surveillance group, OSHA or by other concerned individuals within or outside the Government. These substances will be reviewed by a senior staff group and a decision made as to their incorporation and position in the NIOSH priority list.

NIOSH COORDINATION WITH OSHA

Mr. OBEY. NIOSH professes to maintain a close working relationship with OSHA. What agreements have been established between the two agencies relative to priority development, criteria for developing criteria documents, et cetera.

Dr. SENCER. Copies of the NIOSH priority list have always been sent to OSHA for concurrence prior to finalization, and they have been requested to participate in the development of criteria documents. With the change in top management that took place in OSHA in December 1975, there has been a marked improvement in NIOSH/OSHA working relationships. NIOSH and OSHA currently are meeting on a monthly basis both at the operational and policy levels. These frequent meetings have facilitated the interchange of ideas, and requirements of both agencies, which have strengthened the working relationship.

Mr. OBEY. Does OSHA systematically apprise NIOSH of deficiencies identified in the criteria documents? If so, identify the major deficiencies as described by OSHA, and summarize NIOSH's plans for corrective action.

Dr. SENCER. With the exception of returning the heat stress document, and only then providing general comments, we have not had feedback concerning deficiencies. There have also been general statements that they would like more information concerning feasibility. It is expected, in that OSHA is not initiating rulemaking for criteria documents, that we would begin to see feedback and comments concerning deficiencies. To obtain better knowledge on feasibility, we have formalized our activities involving plant visits to meet two objectives. One is a familiarization of the criteria manager with actual conditions involved in industry and the second is to document instances of successful controls through engineering or good work practices.

Mr. OBEY. Has OSHA indicated to NIOSH what actors or criteria are necessary in a criteria document to facilitate OSHA's standard setting process?

Dr. SENCER. No such communications have been received except OSHA has requested updating of certain criteria documents where they were working on the promulgation of the final standard. In informal discussions with OSHA they have asked NIOSH to develop more fully, information on the feasibility of control technology for a given agent.

CONTRACT VERSUS IN-HOUSE RESEARCH

Mr. OBEY. Why isn't more in-house work performed by NIOSH in developing criteria documents?

Dr. SENCER. In the past, the in-house staff have not been available in sufficient numbers to perform this basic function. However, this is changing and we are currently programed to produce six documents per year in-house. Regardless of how the initial draft document is proposed, all documents receive a series of reviews and a final NIOSH review. We find this to be the most effective use of our professional staff and the various mechanisms for preparing criteria documents.

Mr. OBEY. Provide your evaluation of the criteria documentation contractor's work?

Dr. SENCER. The quality has ranged from very poor to good. In the earlier years, we canceled several contracts and in other instances have had to redo much of the contractor's work. Beginning in the spring of 1974, we entered into a contract with SRI to produce 18 criteria documents. This contract had an award fee mechanism which allowed the Institute to award to the contractor a fee based on an objective analysis of the contractor's performance. This change in contract procedure has brought about a significant improvement in the quality of criteria documents prepared.

Mr. OBEY. What are the responsibilities of NIOSH's criteria managers relative to the projects that are contracted?

Dr. SENCER. Criteria managers are expected to maintain day-to-day contract and review and know the literature and subject as well or better than the contractor. After the first draft they direct changes in the criteria document, as a result of the review meetings which either they or senior NIOSH staff chair.

Mr. OBEY. Does the criteria manager evaluate the factual data disclosed in the contractor prepared document? If so, what basis does the criteria manager use to evaluate the facts?

Dr. SENCER. That is his whole job. He reads the same literature, checks for missing literature, chairs the first external review and subsequent reviews, and is expected to be responsive to all questions concerning the document. He must review all comments on drafts received from external consultants, other governmental agencies and professional societies.

Mr. OBEY. Does OSHA perform subsequent literature searches after receiving the criteria documents? If so, why?

Dr. SENCER. If they do, it probably relates to economic and inflationary impact. NIOSH provides OSHA with an update of literature that becomes available during the period between transmittal of the criteria document and OSHA's initiation of rulemaking.

INTERNAL NIOSH COMMUNICATION

Mr. OBEY. How does illness, injury, and hazard surveillance feed into other NIOSH activities such as field studies, clinical investigations, research, and priority setting?

Dr. SENCER. Hazard surveillance provides a statistical profile of exposures in American industry as reference data for the three activities mentioned in the question. In conjunction with illness and injury data, it can be used to identify potential field studies and clinical investigations. If a field study is undertaken on a specific hazard, it will

provide preliminary data on the kinds of industries, occupations, controls, and potential number of exposures for planning purposes. In priority setting, the most marked impact will be in defining the number of people exposed to the various chemical and physical hazards and assist the Institute in setting priorities beyond the substances now under consideration. Hazard surveillance also will provide, albeit less definitively, data on the extent of controls currently in use. With respect to priority setting other than priorities for criteria document development, it will provide basic information as to number of employees exposed, types of industries, occupational groups involved, controls currently in use, and an indication of current medical programs and monitors.

The illness and injury surveillance program attempts to identify occupational groups with unusual injury and illness experience that may be indicative of response to hazardous exposures in the work environment. Occupations that are found with striking excesses in mortality or mobidity from specific diseases, where there is reason to suspect some factors(s) in the workplace, may become the subject of further research through field studies and clinical investigations. For example, a survey of causes of death among printing pressmen found an increased frequency of oral cancer, emphysema, and heart disease. These results were referred to the field studies program. Since then, an industrywide study of printing trades was initiated. A study of mortality among heavy equipment operators revealed a very high rate of work-related accidents. These findings were transmitted to the appropriate occupational safety focal point in the Institute for consideration in future safety research. Observations of high risks for certain cancers in dairy farmers by the illness and injury surveillance program have prompted the NIOSH agricultural health research program to initiate an in-depth study of cancer mortality among dairymen.

### CRITERIA DEVELOPMENT TIME

Mr. OBEY. NIOSH has been averaging about 18 months to prepare a criteria document. What actions, if any, have been taken to reduce this time frame?

Dr. SENCER. We have consolidated several reviews, and we have also streamlined the final steps involved in the NIOSH Director's review. In essence, we have saved time by reducing the number of iterations of the document.

Mr. OBEY. Could the criteria document process be improved by having NIOSH submit research analysis documents to OSHA rather than writing and recommending specific standards?

Dr. SENCER. NIOSH's providing OSHA with only research analysis documents would probably slow down the process even more. In any event, the act provides for NIOSH to develop recommended standards. It is our opinion that this is best accomplished, at least from a health protection standpoint, by building research analysis into the criteria documentation process.

### LARGE VERSUS SMALL CONTRACTORS

Mr. OBEY. NIOSH appears to be restricting contract negotiations to larger contractors by incorporating multiple criteria documents under one contract (e.g., SRI was awarded a contract for $2.5 million

in 1974 for 18 criteria documents; and another contract in 1975 for $2.3 million for an additional 18 criteria documents). Has NIOSH assessed the impact of concentrating its contracting with selected contractors?

Dr. SENCER. We saw that the process did not work effectively with multiple small contracts. The inconsistencies in approach and thoroughness from one document to another were major concerns. However, we are now concerned with having only one contractor performing in this area and plan to have 2 contracts for 9 documents per year, rather than 1 for 18.

Mr. OBEY. How many contractors can competitively bid on developing 18 criteria documents under 1 contract?

Dr. SENCER. In response to the last RFP for 18 criteria documents, we received 7 bids. This is up from three bids received for the first 18 documents.

Mr. OBEY. Does this practice preclude smaller contractors from competing for contracts?

Dr. SENCER. It probably has inhibited some. However, in the future we are planning on having two smaller contracts for nine documents each. We also continue to have need for assistance on special documents that come along, such as single industry oriented criteria documents. The preparation of criteria document demands input from a broad cross-section of professional talent including physicians, industrial hygienists, toxicologists, engineers, chemists, and pharmacologists. It is very difficult for small contractors to pull together such talent.

Mr. OBEY. SRI employs many former NIOSH officials. Does this offer an unfair advantage to SRI in making contract proposals?

Dr. SENCER. To the best of our knowledge there are only two former NIOSH personnel working for the contractor. One left the Government 10 years ago, long before passage of the Occupational Safety and Health Act, and the other left in 1973. While employees of the Government, neither were involved in the development of criteria documents. One has had previous experience with preparing criteria documents while on the staff of the University of Washington. Experience is only one factor in evaluating proposals submitted by the companies that bid on contracts. I do not believe the presence of these two persons offers an unfair advantage to SRI.

Mr. OBEY. Provide your assessment of SRI's performance to date on the contract negotiated in 1974 for 18 criteria documents.

Dr. SENCER. Their performance has been better than any other previous contract in spite of the very difficult management problems associated with such a large contract.

### SECTION 20(a)(5) AUTHORITY

Mr. OBEY. Has NIOSH used the authority in section 20(a)(5)? If so, how often? If not, why?

Dr. SENCER. NIOSH has not used the authority of section 20(a)(5) of the act. It is recognized that the authority in this section provides a very good mechanism for surveillance of occupational illness, injury and hazard data. However, the section places an extremely large administrative and financial burden on NIOSH because of the re-

quirement for full financial or other assistance to employers that would have to comply to any regulations promulgated by NIOSH to implement the section. Since regulations would probably be promulgated nationwide by type of industry, occupational group, exposure agent, et cetera, the logistics would be tremendously difficult to handle. Also, budget probably could not absorb the costs involved. It is not apparent at this time that the implementation of this section of the act would be immediately cost effective; however, it should be noted that if such a system of recordkeeping could be instituted, it would be of tremendous value in future years for employee medical surveillance purposes and reearch needs.

It is important to note that OSHA in promulgating standards through section 6(b) of the act does require the type of surveillance information mentioned above. This information can be utilized as a research tool for the agent/industries standards so promulgated.

Mr. OBEY. Is cost a factor in deciding on the use of that authority? Are there any cost studies?

Dr. SENCER. Yes; cost is a factor as mentioned in the previous answer. However, no cost studies have been performed.

Mr. OBEY. Would the use of the authority provide useful data for standards development, and at the same time provide some degree of protection to employees pending completion of comprehensive standards?

Dr. SENCER. Very definitely, yes.

Mr. OBEY. Does NIOSH believe the data it has in support of its toxic substances list would, at least in some cases, provide a basis for exercising the authority in section 20(a)(5)?

Dr. SENCER. Yes; probably by feeding into priorities determination.

### PRELIMINARY ACTION ON SUSPECT HAZARDS

Mr. OBEY. Although this question would be better directed to OSHA, does NIOSH believe that it has data, on at least some chemicals on the list, which OSHA could use to promptly issue standards requiring employer reporting, medical monitoring, labeling, or other measures that could provide data and at least some employee protection pending development of comprehensive standards with threshold limit values?

Dr. SENCER. Yes; NIOSH is taking such an initiative in our special hazards activity to develop recommended standards for carcinogenisis, mutagenisis, and teratogenisis.

Mr. OBEY. Could such action by NIOSH and/or OSHA help minimize future occurrences like the kepone situation?

Dr. SENCER. Yes.

### MULTIPLE SUBSTANCE CRITERIA

Mr. OBEY. Has NIOSH notified OSHA of NIOSH's intention to include multiple substances under one criteria document? If so, what was OSHA's response to this procedure?

Dr. SENCER. This has been discussed with OSHA, but a complete response has not been received.

# JUSTIFICATION OF THE BUDGET ESTIMATES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CENTER FOR DISEASE CONTROL

Preventive Health Services


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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,* 1/ 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; [$108,971,000] *$143,293,000:* 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 cost of such training.

[For an additional amount for "Preventive Health Services" for carrying out, to the extent not otherwise provided, section 317 of the Public Health Service Act with regard to Rat Control project grants, $13,100,000.] 2/

1/ Not in conference report because of lack of authorization in 1976.

2/ Language for Supplemental Appropriation Act, 1976, deleted.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CENTER FOR DISEASE CONTROL

Preventive Health Services

Amounts Available for Obligation 1/

| | 1976 | 1977 |
|---|---|---|
| Appropriation | $122,071,000 | $143,293,000 |
| Pending request: Disease Control project grants authorized under continuing resolution | 28,300,000 | --- |
| Comparative transfers to: | | |
| "Salaries and Expenses", Department of State for shared administrative support of overseas posts | -18,000 | --- |
| Subtotal, budget authority | 150,353,000 | 143,293,000 |
| Unobligated balance, start of year | 3,156,000 | --- |
| Unobligated balance, end of year | --- | --- |
| Total, obligations | 153,509,000 | 143,293,000 |

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1976 - $10,000,000; 1977 - $10,000,000.

Summary of Changes

| | |
|---|---|
| 1976 Estimated Obligations | $153,509,000 |
| 1977 Estimated Obligations | 143,293,000 |
| Net Change | -10,216,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Annualization of positions new in 1976 | --- | $1,272,000 | --- | +$139,000 |
| 2. Annualization of pay raises | --- | 3,216,000 | --- | +925,000 |
| 3. Within-grade pay increases | --- | --- | --- | +1,170,000 |
| 4. Payment to GSA for rent | --- | 4,121,000 | --- | +393,000 |
| 5. HEW working Capital fund | --- | 378,000 | --- | +23,000 |
| 6. PHS service and supply fund | --- | 188,000 | --- | +67,000 |
| 7. Office of Federal Employees Health Benefits increase | --- | 422,000 | --- | +34,000 |
| 8. FTS, postage, and utility rate increases | --- | 2,171,000 | --- | +557,000 |
| Subtotal | | | --- | +3,308,000 |
| B. Program: | | | | |
| 1. Laboratory improvement - to integrate the CLIA and Medicare laboratory certification process | 509 | 10,601,000 | +49 | +4,034,000 |
| Subtotal | | | +49 | +4,034,000 |
| Total, increases | | | +49 | +7,342,000 |
| Decreases: | | | | |
| A. Built-in: | | | | |
| 1. One less day of pay | --- | 222,000 | --- | -222,000 |
| Subtotal | | | | -222,000 |
| B. Program: | | | | |
| 1. Disease control - Project grants - reduced level of Federal support | 413 | 41,400,000 | -150 | -7,690,000 |

Summary of Changes -- continued

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Decreases - continued | | | | |
| B. Program - continued | | | | |
| 2. Disease control - Disease investigations, surveillance, and control - for reduced surveillance and TB research | 1,509 | 43,411,000 | --- | -1,503,000 |
| 3. Health education - reduction in Smoking and Health and project evaluation | 36 | 3,513,000 | --- | -531,000 |
| 4. Occupational health - Grants - elimination of Training grant program | --- | 4,900,000 | --- | -3,000,000 |
| 5. Occupational health - Direct operations | 773 | 34,633,000 | -2 | --- |
| 6. Buildings and facilities - Completion of planning phase for Occupational health facility | --- | 4,612,000 | --- | -4,612,000 |
| Subtotal | | | -152 | -17,336,000 |
| Total, decreases | | | -152 | -17,558,000 |
| Total, net change | | | -103 | -10,216,000 |

Crosswalk to Obligations by Activity

Increases:

A. Built-in:

The increase of $3,308,000 includes $1,589,000 for Disease control - Disease investigations, surveillance, and control; $457,000 for Disease control - Laboratory improvement; $33,000 for Disease control - Health education; $649,000 for Occupational health - Direct operations; and $580,000 for Program management.

Decreases:

A. Built-in:

The decrease of $222,000 includes $86,000 for Disease control - Disease investigations, surveillance, and control; $29,000 for Disease control - Laboratory improvement; $2,000 Disease control - Health education; $75,000 for Occupational health's Direct operations, and $30,000 for Program management.

Obligations by Activity

| Page Ref. | | 1976 Revised President's Budget Pos. | 1976 Revised President's Budget Amount | 1976 Appropriation Pos. | 1976 Appropriation Amount | 1977 Estimate Pos. | 1977 Estimate Amount | Increase or Decrease Pos. | Increase or Decrease Amount |
|---|---|---|---|---|---|---|---|---|---|
| | Disease control: | | | | | | | | |
| 123 | (a) Project grants | 563 | 33,710,000 | 563 | 41,400,000 | 413 | 33,710,000 | -150 | -7,690,000 |
| 127 | (b) Disease investigations, surveillance, and control. | 1509 | 43,411,000 | 1509 | 43,411,000 | 1509 | 43,411,000 | --- | --- |
| 132 | (c) Laboratory improvment. | 469 | 9,989,000 | 509 | 10,601,000 | 558 | 15,063,000 | +49 | +4,462,000 |
| 135 | (d) Health education. | 36 | 3,013,000 | 36 | 3,513,000 | 36 | 3,013,000 | --- | -500,000 |
| 137 | Occupational Health: | | | | | | | | |
| | (a) Grants. | --- | 1,900,000 | --- | 4,900,000 | --- | 1,900,000 | --- | -3,000,000 |
| | (b) Direct operations. | 673 | 30,281,000 | 773 | 34,633,000 | 771 | 35,207,000 | -2 | +574,000 |
| 140 | Buildings & facilities | --- | 3,156,000 | --- | 4,612,000 | --- | --- | --- | -4,612,000 |
| 141 | Program management..... | 264 | 10,989,000 | 264 | 10,439,000 | 264 | 10,989,000 | --- | +550,000 |
| | Total obligations | 3514 | 136,449,000 | 3654 | 153,509,000 | 3551 | 143,293,000 | -103 | -10,216,000 |

Obligations by Object

| | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Total number of permanent positions | 3,654 | 3,551 | -103 |
| Full-time equivalent of all other positions | 250 | 250 | --- |
| Average number of all employees | 3,591 | 3,494 | -97 |
| Personnel compensation: | | | |
| Permanent positions | $57,191,000 | $58,400,000 | +$1,209,000 |
| Positions other than permanent | 1,803,000 | 1,803,000 | --- |
| Other personnel compensation | 1,272,000 | 1,272,000 | --- |
| Subtotal, personnel compensation | 60,266,000 | 61,475,000 | +1,209,000 |
| Personnel benefits | 8,178,000 | 8,304,000 | +126,000 |
| Travel and transportation of persons | 3,114,000 | 3,164,000 | +50,000 |
| Transportation of things | 742,000 | 770,000 | +28,000 |
| Rent, communications and utilities | 7,687,000 | 8,394,000 | +707,000 |
| Printing and reproduction | 969,000 | 1,005,000 | +36,000 |
| Other services | 9,597,000 | 6,904,000 | -2,693,000 |
| Project contracts | 18,182,000 | 18,748,000 | +566,000 |
| Supplies and materials | 3,662,000 | 3,927,000 | +265,000 |
| Equipment | 2,213,000 | 2,393,000 | +180,000 |
| Grants, subsidies and contributions | 38,901,000 | 28,211,000 | -10,690,000 |
| Subtotal | 153,511,000 | 143,295,000 | -10,216,000 |
| Less quarters and subsistence | -2,000 | -2,000 | --- |
| Total obligations by object | 153,509,000 | 143,293,000 | -10,216,000 |

Significant Items in House and Senate
Appropriations Committee Reports

| Item | Action taken or to be taken |
|---|---|
| **1976 House Report** | |
| **Buildings and Facilities** | |
| The Committee provided $1,100,000 for buildings and facilities to plan a modern and safe facility at a suitable location for the Research Activities of NIOSH presently located in Cincinnati, Ohio. The Committee expects a full report from HEW by 1/1/76 on the various cities considered for location of the facility, the basis for final site selection, the size and cost of the building and plans for improving working conditions at Cincinnati until the new facility is constructed. | The Senate added an additional $356,000 to complete plans for the NIOSH facility. The appropriation was vetoed by the President. Funds for this project are not available under the continuing resolution.<br><br>A full report has been submitted to Congress. |
| **Lead-Based Paint Poisoning Program** | |
| The Committee expressed its disappointment with CDC's efforts in assisting the other service and Health Financing Programs of HEW to incorporate routine lead screening as an integral part of the delivery of health care. The Committee directed CDC and the Assistant Secretary for Health to redouble their efforts to encourage other health components of HEW to perform routine screening of their patients to detect lead poisoning and expects a full report at the time of the Lead-Based Paint Poisoning Hearings. | The Department continues to emphasize lead screening through several Federal Agencies and non-federal counterparts by developing lead screening guidelines for the early screening, diagnosis, and treatment (EPSDT) programs; through coordination of the Childhood Lead Poisoning Prevention Program (CLPP) and EPSDT; and through liaison between EPSDT and CLPP at the State and local levels. For EPSDT Programs, 17 States now require a screening test for undue lead absorption and 32 of the remaining 33 States provide a reimbursement procedure for lead poisoning screening. CDC has developed or enhanced the lead analysis capability in 28 State laboratories and along with 75 other laboratories, insures their continuing excellence with a Proficiency Testing Program. |
| **1976 Senate Report** | |
| **Health Education** | |
| The Committee directed that an additional $1 million added to the House allowance and budget request be utilized primarily for preventive medicine and that a report be submitted describing what the Center has developed and what progress has been made in the area of Health Education Programs. | Five hundred thousand was allowed by the Conference Committee. The President vetoed the appropriation. Funds are not available under the continuing resolution.<br><br>The directed report is being prepared. |

Authorizing Legislation

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| Preventive Health Services Activity: | | |
| 1. Disease control | | |
| a. Project grants | | |
| Section 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 317(d) (3) of the Public Health Service Act. | 2/ | 5,410,000 |
| b. 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 | 43,411,000 |
| c. Laboratory improvement | | |
| Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act. | Indefinite | 15,063,000 |
| d. Health education | | |
| Sections 301, 311, and 315 of the Public Health Service Act. | Indefinite | 3,013,000 |
| 2. Occupational health | | |
| a. Grants | | |
| Sections 301 and 311 of the Public Health Service Act. | Indefinite | 1,900,000 |
| b. 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 | 35,207,000 |

Authorizing Legislation - continued

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| 3. Program management<br>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 1977 | | 143,293,000 |

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 expired June 30, 1975 - extension of legislation has been proposed.

2/ Section 317(d)(3) of the Public Health Service Act expires June 30, 1976 - extension of legislation has been proposed.

Preventive Health Services

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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 | 152,345,000 |
| 1976 | 96,601,000 | 107,115,000 | 112,471,000 | 122,053,000 |
| Supplemental | 5,410,000 | 10,410,000 | 13,710,000 | 13,100,000 |
| Pending | 28,300,000 | | | |
| 1977 | 143,293,000 | | | |

Justification

Preventive Health Services

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Disease Control: | | | | | | | | |
| (a) Project grants.. | 563 | $33,710,000 | 563 | $41,400,000 | 413 | $33,710,000 | -150 | -$7,690,000 |
| (b) Disease investigations, surveillance, and control. | 1509 | 43,411,000 | 1509 | 43,411,000 | 1509 | 43,411,000 | --- | --- |
| (c) Laboratory improvement.... | 469 | 9,989,000 | 509 | 10,601,000 | 558 | 15,063,000 | +49 | +4,462,000 |
| (d) Health education | 36 | 3,013,000 | 36 | 3,513,000 | 36 | 3,013,000 | --- | -500,000 |
| Occupational health: | | | | | | | | |
| (a) Grants... | --- | 1,900,000 | --- | 4,900,000 | --- | 1,900,000 | --- | -3,000,000 |
| (b) Direct operations... | 673 | 30,281,000 | 773 | 34,633,000 | 771 | 35,207,000 | -2 | +574,000 |
| Buildings and facilities... | --- | 3,156,000 | --- | 4,612,000 | --- | --- | --- | -4,612,000 |
| Program management... | 264 | 10,989,000 | 264 | 10,439,000 | 264 | 10,989,000 | --- | +550,000 |
| Total obligations.. | 3514 | 136,449,000 | 3654 | 153,509,000 | 3551 | 143,293,000 | -103 | -10,216,000 |

General Statement

The Preventive Health Services appropriation provides support for the Center for Disease Control, an agency of the Public Health Service which is the center of competence in the prevention and control of infectious diseases and certain other conditions. CDC's 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 certain environmental hazards, and improving occupational safety and health. This mission is carried out through a multiphasic program which includes: (1) research, investigation, and evaluation of new methods of disease control or provention; (2) 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, CDC is responsible for certain national health functions including the licensure of clinical laboratories engaged in interstate commerce and foreign quarantine activities aimed at preventing the introduction of disease into our Nation.

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Disease control: | | | | | | | | |
| Project grants | | | | | | | | |
| Venereal disease.... | 473 | $19,840,000 | 473 | $19,840,000 | 348 | $19,840,000 | -125 | --- |
| Immunization | 80 | 4,960,000 | 80 | 4,960,000 | 58 | 4,960,000 | -22 | --- |
| Rat control | 10 | 5,410,000 | 10 | 13,100,000 | 7 | 5,410,000 | -3 | -$7,690,000 |
| Lead-Based paint poisoning in children | --- | 3,500,000 | --- | 3,500,000 | --- | 3,500,000 | --- | --- |
| Disease investigations, surveillance, and control..... | 1509 | 43,411,000 | 1509 | 43,411,000 | 1509 | 43,411,000 | --- | --- |
| Laboratory improvement. | 469 | 9,989,000 | 509 | 10,601,000 | 558 | 15,063,000 | +49 | +4,462,000 |
| Health education... | 36 | 3,013,000 | 36 | 3,513,000 | 36 | 3,013,000 | --- | -500,000 |
| Total..... | 2577 | 90,123,000 | 2617 | 98,925,000 | 2516 | 95,197,000 | -101 | -3,728,000 |

Project grants

These project grant activities would be consolidated in the State bloc grant program prepared for later transmittal.

Venereal Diseases

The incidence of syphilis and gonorrhea remain at unacceptably high levels, but favorable changes in disease patterns and control program activities are being witnessed in 1976 and should continue in 1977. Major emphasis continues to be placed on control programs for these two diseases because they are highly communicable and cause major disability if not treated early in the infection, and control methodologies are available. Because the population is extremely mobile and high rate of inter- and intrastate disease transmission occurs, and because intervention activities often require cooperative follow-up by two or more States, control efforts must be carried out uniformly on a national basis.

Project grant funds are awarded to official health agencies principally to support disease intervention activities at the State and local level. The primary objectives of these programs are (1) screening high risk female populations for gonorrhea; (2) surveillance of syphilis through serologic screening of specific population segments; (3) providing contact referral services to patients with infectious syphilis and gonorrhea; (4) providing venereal disease facts to people at risk to prevent exposure to venereal disease and to influence infected individuals to seek early medical care; and (5) involving the private medical community in all aspects of venereal disease control. During 1977, screening programs for gonorrhea will become more focused as nonproductive screening efforts are discontinued and as post-treatment and periodic rescreening of both male and female gonorrhea patients is implemented. Greater emphasis will be placed on simultaneous treatment of steady sex partners, particularly through greater involvement of patients in referring their sex partners to medical care. Each of these gonorrhea program efforts reduces both the cost of contact follow-up and the likelihood of immediate exposure of the patient to reinfection. Syphilis epidemiologic case management efforts will be strengthened to maximize the impact of contact referral and epidemiologic treatment on case prevention, and to

continue to gear health department policies and control program activities to specific high risk groups, particularly the gay community, which has emerged as a group for which specially tailored control programs have proved very effective.

Educational efforts during 1977 will focus on providing information about venereal disease to persons at high risk of acquiring infection, specifically to the person with a history of repeat infections, in an attempt to reduce further reinfection and transmission of disease. Physicians will be encouraged to simultaneously treat sex partners and involve patients in the referral of their sex partners to medical care.

During 1977, we will also continue to generate increased support of venereal disease control programs by State and local governments and other Federal sources. Some of the cuts in Federal project grants in 1976 were offset by supplemental funding of $1.6 million in seven project areas through the Job Opportunities Program of the Public Works and Economic Development Act (Title X).

The trends in recently acquired syphilis continue to be mixed as indicated below:

| | 1974 | 1975 | Percent Change |
|---|---|---|---|
| Primary and Secondary (total) | 24,728 | 25,746 | +4.1 |
| Males | 17,079 | 18,415 | +7.8 |
| Females | 7,649 | 7,331 | -4.2 |
| Early Latent (total) | 24,290 | 26,166 | +7.7 |

The national increase in syphilis has resulted from large increases in a few areas of the country, and as indicated above, has largely been limited to males. However, early 1976 data show a decline in primary and secondary syphilis.

Although the annual percentage increase in the incidence of gonorrhea has slowed from 12.7 percent in 1973, to 8.0 percent in 1974, to 7.4 percent in 1975, gonorrhea continues to rank first among all reportable diseases. It continues to be reported most frequently from the 63 large cities with populations of 200,000 or more. These cities, comprising 28 percent of the Nation's population, accounted or 53.4 percent of the reported cases during 1975. However, 23 of these cities reported a decrease in gonorrhea in 1975, and the overall increase in gonorrhea in the 63 cities was 4.2 percent compared to 11.3 percent for the rest of the nation.

In screening programs for gonorrhea during 1975, 8,863,899 culture specimens were obtained from women. Of those cultured, 375,863 (4.2%) were positive for gonorrhea, and treatment was documented for 92 percent of the women with positive results. Because of gonorrhea screening and other outreach efforts, infected women are being treated earlier in their infection and removed from the infectious reservoir thereby preventing further spread of the disease and development of the serious complications of gonorrhea. The fact that positivity rates from screening programs have remained relatively stable at 4.2 percent suggests that the incidence of gonorrhea among females may, in fact, be stabilizing.

## Immunization

During 1977, grants will continue to be provided to assist States and localities in carrying out immunization programs, although Federal contributions to each program will be reduced. States and localities will be expected to support an increased share of routine vaccine costs and delivery systems from non-project grant resources. We anticipate using project grant funds to put special

emphasis on developing the capability of States in rapidly identifying and containing outbreaks of disease. These activities will be based on the experience of several pilot areas in the north central part of the country which are now carrying out intensive measles containment programs. In addition, grantees will be encouraged to refine overall assessment activities in order to pinpoint pockets of high disease susceptibility before outbreaks of disease occur, and to carry out targeted immunization programs to improve the level of protection against vaccine preventable diseases among pre-school children in these groups.

During calendar year 1974, most childhood vaccine preventable diseases continued to decline with measles, rubella, and polio reaching all time lows since national statistics have been collected. According to the 1974 Immunization Survey, the level of protection against all of these diseases had increased slightly in all age groups compared to 1973, with approximately 60 percent of all pre-school children protected by vaccine against rubella, 63 percent against polio, 65 percent against measles, and 74 percent against diphtheria, tetanus, and whooping cough. However, there is known to be considerable variation in protection levels among various population subgroups, with vaccine protection being particularly low among the urban and rural poor. This disparity continues, although the 1974 survey suggests that the gap has been narrowed slightly.

Morbidity reports for the first eleven months of calendar year 1975, however, show that both measles and rubella are increasing once again. Rubella morbidity was up 38.7 percent over the same period a year ago, and measles morbidity was up 7.9 percent. It is anticipated that the measles containment programs being implemented on a pilot basis will prove effective in substantially curtailing the spread of disease among susceptible children. The key elements of this strategy, which are similar to those employed in the worldwide smallpox eradication program, are a sensitive surveillance system which identifies outbreaks of disease early, and a rapid response capability to vaccinate susceptible children who are at immediate risk of exposure. Both measles and rubella vaccinations are provided. This approach permits health departments to target their resources on interrupting transmission of measles and rubella, and at the same time it facilitates the identification of pockets of high disease susceptibility. Operating in conjunction with ongoing immunization programs, including mass public and professional awareness campaigns, it is anticipated that both measles and rubella morbidity can be substantially reduced.

Rat Control

Since 1969, project grants have been awarded to urban areas to reduce rat infestations and to insure the maintenance of rat control programs by local and State governments and through voluntary community action. During 1976, these grants are being provided for the first time under the disease control authority of section 317 of the Public Health Service Act, which should simplify their administration and give recognition to the similarities between rat control and disease control programs in terms of operational strategies and target populations. The existing technology for reducing rat infestations has been successfully demonstrated, and local areas and States are demonstrating the capability to participate fully in maintaining control once it has been established.

During 1977, priority will be given to providing continuation funding to projects in communities with the most severe rat problems and those which are developing sound control programs and have substantial State or local financial support. The Federal share of each of these projects will be reduced. States and local communities will be expected to increase their contribution to insure that no regression occurs in rat control activities. It is anticipated that this level of funding will support approximately 50 community programs through 30 to 35 project grants.

At the present time, 64 program communities supported through 39 project grants are currently serving 6,000,000 people. Most of these activities are being supported through grants made late in 1975. By the end of 1976, it is expected that 21,000 of the total 40,157 target blocks will reduce rat infestations and the conditions conducive to such infestations to a point where routine maintenance operations will be sufficient to sustain the progress that has been made. Additional progress is expected in reducing rat problems in some 10,581 blocks which are in the intensive rat reduction phase of the program.

With 1976 funds, we anticipate providing continued support to 60 of these community programs, with responsibility for maintenance activities in many existing blocks being turned over completely to State and local governments for support. This funding will pave the way for full termination of Federal support to approximately 10 of these communities in 1977, and for reduced Federal support to most of the remaining community programs. Program regression during 1976 and 1977 is to be prevented by increased State and local contributions to these programs, and through the use of other sources of Federal assistance. During 1976, approximately $1,000,000 was provided as supplementary funds to seven urban rat control grantee communities under the Job Opportunities Program of the Public Works and Economic Development Act (Title X).

Lead-Based Paint Poisoning in Children

Project grants for the control of lead-based paint poisoning in children are made to assist communities in developing child screening and follow-up programs. These grants are used primarily to develop an active lead-based paint poisoning prevention program which can coordinate lead screening and follow-up activities of other child health programs, and supplement these activities by providing an active outreach effort in neighborhoods where lead-based paint is accessible to children. The abatement of environmental lead hazards in residential dwellings of affected children is required, although costs for these actions generally are not supported by project grant funds.

Funds available in 1977 will be awarded only to those programs which continue to document a significant problem and which have developed productive programs. The number of projects funded is expected to remain at approximately 30 to 35. It is estimated that 250,000 children will be screened in these projects, and 20,000 will be found with undue lead absorption. Additional children will continue to be screened by Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs under Medicaid, and Maternal and Child Health (MCH) programs of the Public Health Service.

For the fiscal year ending on June 30, 1976, 71 project communities will screen an estimated 525,000 children for undue lead absorption, utilizing project grant funds awarded late in 1975. It is estimated that 34,200 children will be placed under pediatric management for undue lead absorption with approximately 4,400 children requiring chelation therapy. Appropriate lead abatement action will be carried out in 75 percent of those houses found with a lead hazard.

The 1976 appropriations will be used to continue support to approximately 35 of these projects which are faced with the most severe lead poisoning problem, and which have developed effective programs. With increased State and local support, and with full implementation of a newly developed and much cheaper screening procedure, 1976 funds will enable these programs to screen approximately 250,000 children during 1977, and to identify 25,000 children with undue lead absorption. It is assumed that in those communities not receiving project funds where a significant lead-based paint poisoning problem exists, States and localities will continue the necessary activities with their own resources. Additionally, there are other Federal funds which can be used to carry out some of the program elements where local officials determine it necessary. These include the EPSDT program; the Job Opportunities program (Title X of the Public

Works and Economic Development Act); the Comprehensive Employment and Training Act (CETA); MCH programs; and Title I of the Housing and Community Development Act of 1974. Some funds from these programs will also be used to augment the activities of the funded projects. It is estimated that in addition to the 250,000 children screened by the funded projects, 300,000 children will be screened by EPSDT and MCH programs during 1976.

Disease investigations, surveillance, and control

This budget activity supports a wide variety of public health functions aimed at control of a multitude of diseases and conditions, and represents the major aspect of the preventive health activities. The scientific and technical competence and facilities which are devoted to this work represent a valuable national health resource.

Surveillance

The Center for Disease Control maintains surveillance over diseases of public health significance occurring in this country or presenting a threat of introduction from other nations. Surveillance reports for 30 diseases were issued in 1975 with an approximate average circulation of 5,000 for each report.

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 42 State and city health departments throughout the United States. Approximately 1,350 separate disease outbreaks will be investigated during 1976 in collaboration with local health workers, and an estimated 1,500 such investigations will be conducted during 1977.

In 1976, the Center processed 140,000 of the most difficult reference diagnostic specimens from throughout the Nation. Approximately 1.8 million different determinations were made on these specimens. For 1977, a modest growth is expected in this area.

Nosocomial infections - Infections developed during hospitalization constitute a serious public health problem. Based on limited data, it is broadly estimated that hospital infections add seven days to the average hospital stay, increasing the cost of health care in this country by more than $1 billion.

To gain better knowledge of the nature and scope of the problem, CDC conducts a continuous surveillance program, called the National Nosocomial Infections Study (NNIS), involving 80 hospitals. Infection control personnel make telephonic surveillance reports daily to CDC. This data is used to evaluate infection control efforts and as a basis for investigating important public health problems.

In addition, CDC is undertaking a major retrospective study designed to accurately determine not only current prevalence of hospital infections, but also the effectiveness of infection control in terms of improved patient health, reduced hospital stay, and lowered health costs. The Study of the Efficacy of Nosocomial Infection Control (SENIC) is a study which can serve as a basis for hospital infection control decisions for many years into the future.

Influenza - Nationwide influenza surveillance from various reporting levels encompassing 400 institutions in 138 cities was continued and expanded upon in 1976.

With the recognition of a new strain of influenza virus A/Victoria strain in several Western Pacific countries this past fall, intensified influenza surveillance efforts were mounted. Influenza-like illness was monitored among travelers and computerized summaries of State influenza morbidity and mortality data were regularly provided to each State health department during the influenza season.

Hepatitis - Nationwide surveillance of viral hepatitis will continue in 1977 with expansion of efforts in certain hospital and community settings. Epidemiological factors, such as hospitalization, prior surgery, and dental manipulation, will be studied to pin-point changes in occurrence of hepatitis B and to assess more accurately the factors related to hepatitis B transmission. Efforts to identify hepatitis A cases related to day care centers will be intensified in hopes of controlling possible epidemics within the day care center. Nationwide surveillance of viral hepatitis will focus upon identification of high risk groups in need of hepatitis B immune globulin for prevention of hepatitis B.

Birth defects - Surveillance and epidemiologic studies of birth defects continued in 1975-1976 using data compiled from locally-based surveillance programs. In addition, the nationwide Birth Defects Monitoring Program provides data on approximately one million births a year which are used in examining more national patterns. From these activities, the Center will be able to monitor the occurrence of defects and undertake descriptive and analytic studies of particular birth defects.

Smallpox - Surveillance of suspected smallpox cases has become increasingly more important with the change in vaccination policies and the continuing success of the Smallpox Eradication Program. The geographic area affected by endemic smallpox steadily declined in 1975 as it has been doing since the worldwide Smallpox Eradication Program began in 1967. The Center for Disease Control continued to furnish on-site technical advisors during 1975 for both long and short-term assignments to smallpox endemic areas. Currently, the smallpox endemic area appears limited to Ethiopia where accelerated efforts are underway with considerable WHO financial and technical input. Expectations are that Ethiopia will be free of smallpox during 1976, and the original target of "a smallpox-free world in 10 years," established by the World Health Organization in 1966 will be achieved. This will be the first time in history that man has succeeded in eradicating any disease. The tactics used to achieve this were substantially developed and perfected by the Center for Disease Control in West Africa and extended by CDC personnel to other smallpox endemic areas. During 1976, CDC also furnished technical advisors through WHO to assist in assessment activities to confirm geographically smallpox-free areas. This support will continue in 1977.

## Investigations

The Center for Disease Control conducts clinical and epidemiological investigations of selected diseases of public health significance which are carried out both in the laboratory and in the field on infectious and certain noninfectious diseases and conditions.

Viral diseases - During 1976, epidemiologic assistance was provided to various State health agencies during the largest and most geographically widespread outbreak of St. Louis encephalitis (SLE) ever recorded. Epidemic assistance was also provided to North Dakota and Minnesota during an outbreak of western equine encephalitis (WEE).

Laboratory technology has been advanced to the state where it is now possible to recover, repeatedly, the hepatitis A virus (HAV) from chimpanzee and human cases of disease using biophysical techniques. As a result, a new serologic test using an antibody to HAV, has been developed and is being evaluated. In 1977, this test will be refined to the point where large scale national prevalence studies can be initiated to identify populations at high risk.

In 1976, rapid techniques for detection of virus and antibodies were developed for the highly pathogenic Marburg and Lassa fever viruses. Worldwide diagnostic service for these and similar viruses continues to be provided. The expanded maximum security laboratory at CDC, when completed, will provide the specialized facilities needed for laboratory activities involving highly infectious diseases. Work continues on basic immunologic problems as a basis for developing vaccines for hazardous viruses.

Bacterial diseases - During 1975 and 1976, many significant bacterial disease epidemics were investigated by the CDC. Examples of such investigations are: (a) outbreaks of intestinal illness aboard passenger cruise ships; (b) a commercially canned beef-stew product that caused an outbreak of botulism, and (c) one of the largest outbreaks of salmonellosis ever recorded, was caused by faulty food handling practices and improper storage of food.

Streptococcal diseases continue to persist as major public health concerns. Rheumatic heart disease following streptococcal infections affects some 100,000 Americans annually, with an estimated mortality of about 16,000. Research has yielded a test which will add materially to knowledge of better control measures against rheumatic heart disease.

Of equal importance is illness or death of newborns and infants up to 2 years of age who suffer from disease caused by group B streptococci. During 1976, investigations resulted in the development and perfection of a technique to serologically type group B streptococci. During 1977, research will be conducted to develop a reliable and practical laboratory procedure to measure the level of protective antibodies to the group B virulence factors.

A third streptococcal disease of public health importance causes dental caries. During 1976, in collaboration with the National Institute of Dental Research, procedures were developed for the production of diagnostic reagents which will identify plaque-producing streptococci by direct microscopic examination of plaque material obtained from patients with dental caries.

Parasitic diseases - The Center continues to operate a diagnostic serology program for the diagnosis of 23 parasitic infections. During 1976, a new technique was evaluated for the diagnosis of toxoplasmosis. Tests are being evaluated for the detection of organisms in tissues and cerebrospinal fluid which are the cause of serious eye lesions and infections which usually result in death. Collaborative studies on the standardization of diagnostic test reagents for malaria and toxoplasmosis were initiated. During 1977, the standardization of reagents will be emphasized.

Field investigations of several parasitic diseases and a survey of intestinal parasites in Vietnamese refugees were carried out in 1975 and 1976.

Fungal diseases - Fungal diseases constitute important public health problems and in recent years there has been a phenomenal increase in diseases caused by fungi. Deaths directly attributed to pathogenic fungi have averaged 300 per year over the past decade.

To aid the many hospitals and health departments that lack competency, the Center provides a national diagnostic service for fungal diseases. To enable physicians to select the proper chemotherapeutic agents and dosages, the Center initiated a service during 1975 designed to test the sensitivity of fungal isolates to various antifungal drugs.

In 1977, studies will continue on the development of serodiagnostic procedures and the evaluation of a diagnostic blood test will be completed for mycotic diseases being recognized with increasing frequency, for which serologic tests are urgently needed.

Noninfectious diseases - Investigative activity in the area of cancer during 1976 has concerned both viral tumor causation and environmental hazards. Work has continued on analytic studies concerned with (a) the concept that leukemia/lymphoma may be spread from person-to-person, and (b) the combined laboratory/epidemiologic search for antibody against feline leukemia virus among persons exposed to cats shedding such viruses. Studies relating to vinyl chloride exposure have continued concerning patterns of lung cancer among vinyl chloride workers and follow-up of angiosarcoma of the liver cases throughout the U.S..

Projected studies for 1977 will involve continuation of the various studies outlined above; in particular, those related to lung cancer, lead, and feline leukemia virus.

## Control

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 States and communities in the conduct of their public health programs. Activities include operational research, development of control strategies, and technical assistance, as well as minimal regulatory operations at ports of entry.

Venereal disease - Major efforts during 1976 were directed toward strengthening syphilis control methodologies, refining gonorrhea control strategies and techniques, and developing initiatives for the study of other sexually transmitted diseases. Technical assistance was devoted to reviewing progress in methods of control and new strategies and in developing awareness and surveillance activities for the increasing problem of sexually transmitted diseases (STD's) other than syphilis and gonorrhea.

These efforts will continue in 1977. Emphasis will be placed on (a) developing alternative VD casefinding approaches among male homosexuals; (b) national monitoring to study increasing resistance of GC strains to antibioties; (c) shifting to posttreatment and rescreening of GC patients; (d) renewed research efforts to define additional risk factors, diagnostic techniques, and treatment for pelvic inflammatory disease (PID); and (e) development of control measures for other sexually transmitted diseases (STD).

Tuberculosis - The reported tuberculosis incidence in the United States for calendar year 1974 was 30,122 cases, a reduction of 2.8 percent from calendar year 1973. Preliminary figures for calendar year 1975 show an anticipated increase in reported tuberculosis morbidity, partly accounted for by a change in reporting requirements as of January 1. Because of this reporting change, 1975 figures are not strictly comparable with those of previous years. However, there may be a leveling off of the average 5 percent annual decline in reported new cases of tuberculosis which was observed during the late 1960's and early 1970's. A major activity for 1976 and 1977 is to provide an indepth analysis of areas showing increases in reported tuberculosis morbidity to determine causes of the increases and to assess what changes in control program activities might account for the increases or might be indicated to combat the increases.

During 1977, the Center will continue its efforts to assist health care providers to realign programs and reallocate resources so that a more effective tuberculosis control program can be accomplished. Also, efforts will be aimed at improving laboratory surveillance and developing pharmacy surveillance in hospitals and clinics. Operational research activities during 1977 will continue the effort to develop methods of quicker and more precise diagnosis of tuberculosis and to assess shorter and more effective regimes for preventive treatment of tuberculous infection and treatment of tuberculosis.

Immunization - This past fall, for the third consecutive year, an intensive motivational and educational campaign called Immunization Action Month (IAM) was coordinated by the Center in an attempt to reduce declining trends in immunization levels. Data from the 1974 United States Immunization Survey reveal a small increase in the 1-4 and 5-9 year age groups who are immune to all of the common vaccine preventable diseases which indicates success of earlier campaigns. Data from the 1975 survey are not yet available. A similar campaign will be conducted in 1977.

Several pilot programs were initiated in 1976 to assess the results of the implementation of an intensive measles containment program similar to the approach used in the smallpox eradication program. During 1977, the Center will continue to refine immunization control strategies.

Environmental Health - The Center also has an active technical assistance program in the broad area of environmental health. Priority is being given to work with State health agencies in an effort to re-establish a strong environmental health technical capability within these organizations. During 1976, a comprehensive survey of environmental health programs in nine States was completed. Information from this study is being used to develop a strong technical assistance program for the Center during 1977.

During 1976, the Center, with assistance from a variety of camping organizations and camp safety officials, completed the development of suggested State statutes and regulations for youth camp safety. In addition, special health and safety standards for high risk activities in youth camps are also being developed. Health and safety standards will be expanded for several other aspects of camping and published in 1977.

Quarantine operations - Foreign Quarantine Regulations are being revised consistent with current scientific knowledge and medical expertise and the status of health in the worldwide community.

The revised Vessel Sanitation Inspection Program was implemented in 1976. CDC has assumed the responsibility for inspecting all passenger vessels arriving from foreign areas. Results of sanitation inspections indicate acceptance and compliance with CDC recommendations on the part of the passenger cruise industry.

Summary - Funds available in 1977 for this activity include a net built-in change of $1,503,000 for annualization of positions new in 1975, annualization of pay raises, within-grade pay increases, HEW Working Capital Fund, PHS Service and Supply Fund, Office of Federal Employees Health Benefits increases, FTS increases, postage and utility rate increases, partially offset by one less day of pay, and a program decrease in the amount of $1,503,000 resulting from reduced activities in surveillance of diseases such as cholera and plague; surveillance of rabies along the U.S.-Mexico border; sexually transmitted diseases other than syphilis and gonorrhea; and tuberculosis research.

Laboratory improvement

More than 4 billion clinical tests are done annually in the laboratories of this Nation. The accuracy of these tests determines, in many cases, the quality of diagnosis, preventive care, or treatment the American citizen will receive. CDC administers a multi-faceted program to improve the capability of the Nation's more than 14,000 clinical laboratories and to upgrade the quality of the tests and materials used by these laboratories. This is accomplished primarily through (a) technology development - a continual program of creation, refinement, application, review and appraisal of the laboratory tools needed for high quality clinical laboratory performance; (b) technology transfer - encouraging the application of effective procedures and materials to the tasks of the clinical laboratory.

To accomplish its objectives, CDC operates a national reference laboratory service and conducts extensive field and laboratory investigations. CDC provides assistance to laboratories of States, large municipalities, and, under the auspices of the World Health Organization (WHO), foreign countries in the form of consultation, laboratory management service, and dissemination of new and improved procedures. CDC assists in developing 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 major functions include (1) providing extensive remedial short-term instruction programs in laboratory practice, with emphasis on helping State laboratories provide short-term training to clinical laboratorians; (2) conducting a long-term postdoctoral residency program in microbiology to develop broad competency in supervisory health laboratory personnel; (3) producing and distributing microbiological reference reagents for standardization and quality control purposes; (4) evaluating commercial reagents; and (5) distributing experimental vaccines and special immune globulins.

Specific activities for 1977 include:

1. Identification of Needs - CDC has found, over the years, that its programs of technology development, its contacts with State health laboratories, and its laboratory evaluation programs, including licensure and proficiency testing, have been able to effectively identify areas of need for technology development and training. The Center continues to expand its proficiency testing and on-site laboratory evaluation activities both in number of participating laboratories as well as numbers and types of constituents tested. Technical areas which are of increasing concern due to test volume and/or difficulty of tests performed and their clinical importance are emphasized. For 1977 some of these are: blood lead determinations, especially in children; blood levels of digoxin, a drug used in heart disease therapy, which must be continually monitored; alkaline phosphatase which is important in the diagnosis of bone, liver and prostatic cancer; and magnesium deficiencies which are of increasing clinical importance. In hematology, a new method for evaluating the technologist's ability to correctly read differential blood films will be employed. Review of the competency of cytotechnologists in screening vaginal and cervical smears for cancer will continue as will a survey of national competency in identifying carcino-embryonic antigen (CEA) in serum, a relatively new test used in cancer control. Findings from these activities will be directly applied to technology development and training activities.

2. Regulation - CDC has, since the passage of CLIA, utilized the regulatory process as one means of accomplishing laboratory improvement. Since that time, constant efforts have been made to meld the CLIA and the Medicare laboratory certification process so that the programs are uniform and non-duplicative. In the interest of economy and effectiveness and to insure maximum uniform coverage of the Nation's approximately 14,000 clinical laboratories, CDC has entered into an agreement with the Bureau of Health Insurance, Social Security Administration, and the Bureau of Quality Assurance, Health Services Administration which provides for an integration of functions. Bureau of Health Insurance will, through its State contracts, evaluate both CLIA laboratories and Medicare laboratories, with State examiners using the CDC-initiated standards and checklists. It will also provide for appropriate adverse actions against CLIA as well as Medicare-certified independent and hospital laboratories. The Center assumes the responsibility for oversight monitoring of the effectiveness of each State program and each surrogate evaluation program, including those of the College of American Pathologists, and the Joint Commission on the Accreditation of Hospitals. States will be expected to provide or approve a proficiency testing program equivalent to the performance evaluation program applied to CLIA laboratories. CDC will provide proficiency testing for CLIA and Medicare laboratories where States do not have equivalent programs. In the event that the monitoring program finds some part of a State evaluation program less stringent than that of CLIA, the Center will directly evaluate all Medicare and CLIA laboratories in that State until the State evaluation program can be upgraded. CDC will continue to initiate scientific and technical standards for application to both CLIA and Medicare laboratories in the areas of personnel, quality control, and proficiency testing.

3. Training - CDC has an active, effective, long-standing program of training directed toward areas which have been identified as appropriate high priority national needs. In 1977, the Center's laboratory training activities will emphasize support of State and local continuing education programs. Consultation will be provided to approximately 40 States in planning and conducting more than 100 courses for laboratorians with specific technical needs as determined by various laboratory evaluation programs. In addition, 50 on-site consultations will be provided to State health departments in organizing and improving their training programs. Another 1,000 supervisors with teaching duties will be trained in CDC headquarters courses which require expertise, equipment, and/or facilities not available in all States. These supervisors will multiply the technology transfer activities through direct instruction to their employees or involvement in State and local courses. As always, training materials developed at CDC will be available for use by any qualified public or private agency in its training activities.

4. State Assistance - Laboratory improvement is best effected by a combination of Federal, State (and local) assistance and motivation, utilizing the resources of private professional groups to the fullest feasible extent. In addition to the assistance provided to State continuing education programs, the Center continues to provide technical consultation to upgrade procedures used in State health laboratories in their roles as the first line diagnostic and reference laboratories in backstopping clinical laboratory operations. In addition, the Center will continue efforts to upgrade the capabilities of States to conduct laboratory improvement programs within their own borders. Such activities as on-site inspection of facilities and quality control practices, proficiency testing, technical consultation and remedial training can best be accomplished by the States with support from the Federal government. Not only is technical and management consultation necessary to improve State programs but financial assistance is also imperative. This assistance would take the form of developmental assistance contracts.

Additional resources in 1977 includes a net built-in increase of $428,000 for annualization of pay raises, within-grade pay increases, FTS, postage and utility rate increases, partially offset by one less day of pay; a program increase of $4,034,000 which would allow the Center to carry out its responsibilities under the aforementioned agreement, including increased on-site surveillance of laboratories, provision of proficiency testing services to laboratories not otherwise covered and increased direct technical assistance in the development of State remedial training capabilities. The Center also would provide financial assistance in the form of developmental assistance contracts to States which have demonstrated a real interest in upgrading their intrastate programs. Such assistance, when extended to all States, would provide for the full gamut of laboratory improvement activities from regulatory monitoring to technical training and consultation designed to insure adherence by clinical laboratories to minimal levels of performance, regardless of size, type or geographical location.

Health education

Thousands of deaths and illnesses occur in the U.S. each year because the American people are not fully aware of the important role lifestyle can play in maintaining or harming health. Many premature illnesses and deaths can be prevented by decisions individuals can make to protect their own health.

To assure that all Americans can make informed health decisions, and to motivate them to take action to improve their health status, the Center for Disease Control provides coordination for a national health education program. The program encourages broad use of the Nation's health care system in its many ramifications so as to prevent unnecessary disabilities or death.

In 1977, emphasis will be placed by the CDC on coordination of health education activities already underway in various agencies of the Department of Health, Education, and Welfare. The CDC's role is not to proliferate health education programs or to establish unnecessary new activities, but to provide direction to and channel ongoing education programs so they will have the strongest possible impact.

Working through the Intra-Departmental Panel for Health Education of the Public, CDC's Bureau of Health Education will assure that appropriate attention is given to health education in all ongoing programs. It will establish a system for maintaining currency of health education activities throughout the Department. CDC will assist in developing guidelines to implement the health education priorities of the National Health Planning and Resources Development Act of 1974 and will intensify activities to assist HEW Regional Offices, other Federal agencies and State, local and private organizations to fulfill their health education responsibilities. To this end, the CDC will serve as a central source of information, expertise and referral in any area of health education.

During the next fiscal year the Center will develop effective health education approaches to specific health problems of defined target populations--the aged, youth and children, ethnic and linguistic minorities, urban poverty groups, rural poverty groups or those in special industrial areas--by initiating research, demonstration and evaluation projects. These will be designed to: (1) document the methods used in, and outcomes of, specific health education approaches; and (2) document criteria and methods for evaluating health education programs.

Research, demonstration, or evaluation projects will be carried out in cooperation with neighborhood health centers, schools, Agricultural Extension Services and other existing facilities which have demonstrated success. Other projects will involve initial programs with the newly formed "National Center for Health Education," comprised of private health groups, and the continuation of surveys of smoking prevalence among teenagers, adults, and health professionals.

The Center will provide health professionals, others who provide health services, and researchers, effective tools to assist in managing health problems related to smoking by: (1) compiling, producing, and distributing a desk reference containing a summary of the significant scientific evidence and health problems related to cigarette smoking and a bulletin containing the world's current technical information on smoking and health; and (2) initiating a system for periodically updating and distributing the desk reference and evaluating its use.

In 1977, the Center, through the National Clearinghouse for Smoking and Health, will collect, review and analyze more than 2,000 scientific articles to prepare the annual report to Congress on the Health Consequences of Smoking; it will distribute more than 10,000 copies of the Directory on Ongoing Research on Smoking and some 4,000 copies of a Smoking and Health Bibliography. It will continue to handle some 30,000 public inquiries related to smoking and health, though this system will be broadened through a project initiated to assist State and local health agencies in establishing and maintaining systems to respond to inquiries about smoking and health. Projects will be started with non-profit and private organizations to develop and implement new distribution systems for both general health and smoking education materials. These projects will involve the National Interagency Council on Smoking and Health (composed of the principal voluntary and professional organizations concerned with reducing death and disability from smoking), industrial communications organizations, and mass media organizations.

The collection and distribution of technical information, currently devoted primarily to the smoking and health problems, will be extended in 1977 to include other subject areas related to health education. In the Center's effort to improve the Nation's health by prevention of disease, health education will play a pivotal role by assuring that American people have information necessary to act in their own best interest.

A decrease of $500,000 results from a net built-in increase of $31,000 for annualization of pay raises, within grade increases, FTS increases, postage and utility rate increases and one less day of pay; and a program decrease of $531,000 in smoking and health education project evaluation.

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| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Occupational health: | | | | | | | | |
| Grants ..... | --- | $1,900,000 | --- | $4,900,000 | --- | $1,900,000 | --- | -$3,000,000 |
| Direct operations. | 673 | 30,281,000 | 773 | 34,633,000 | 771 | 35,207,000 | -2 | +574,000 |
| Total .. | 673 | 32,181,000 | 773 | 39,533,000 | 771 | 37,107,000 | -2 | -2,426,000 |

The National Institute for Occupational Safety and Health provides the basic federal research effort to assure healthful and safe working conditions through: intramural research, research contracts, agreements with other federal agencies, and research training grants to qualified institutions. This research is directed towards the development of effective standards and work practices to prevent, avoid, and/or ameliorate unsafe and unhealthful working conditions.

Grants

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. Specific efforts will be directed toward NIOSH high priority areas, especially support of criteria development for standards or standards supplementation, occupational carcinogenesis, agricultural safety and health, and motivational and behavioral factors research. It is expected that 34 research grants in the amount of $1,900,000 will be awarded in 1976 and 1977.

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 1976, it is expected that 50 training grants in the amount of $3,000,000 will be awarded to continue active grant supported training programs and initiate new grants.

The decrease of $3,000,000 results from the one-time funding in 1976 of the training grant program.

Direct operations

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 to complete development of 24 criteria documents (this includes 16 planned and 8 that have slipped from previous years). It is anticipated that the number of hazard evaluations will be approximately 70 for 1976. The number of persons trained on a reimbursable basis will remain approximately 1,300 per year.

During 1976, the Institute will:

1. Complete development of 24 criteria for occupational safety and health standards including: sodium hydroxide, carbon tetrachloride, emergency egress, chromium (VI), oxides of nitrogen, and zinc oxide. It is anticipated that 26 criteria documents will be completed in 1978 resulting from the program increase in 1976.

2. Test and certify more than 100 protective devices and industrial hygiene monitoring devices;

3. Publish the sixth annual "Registry of Toxic Effects of Chemical Substances";

4. Provide response to an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung benefits;

5. Complete approximately 70 health hazard determinations in response to requests from employers or authorized representatives of employees for determination of whether substances normally found in their place of employment have potentially toxic effects;

6. Process approximately 17,000 coal miners' chest roentgenograms (X-rays);

7. Provide 1,300 man-weeks of training on a fee-for-service basis;

8. Define chemical or industrial processes which manufacture or use suspected carcinogens. There is a need to screen new chemicals before they become part of industrial processes and escape into the environment. New legislation, such as the proposed Toxic Substances Control Act, is needed to establish a system of pre-market screening of new chemicals.

9. Develop methodology for the acquisition and analysis of occupational data on a continuing basis for persons disabled by cancer.

10. Identify, through record studies, occupational groups associated with unusual frequency of cancer of specific organs.

11. Initiate 15 industry-wide studies which will include both environmental and medical epidemiological investigations. These studies will be conducted when there is evidence that a particular occupational group is experiencing an unusual rate of cancer, or when there is documented evidence of animal carcinogenicity related to a particular substance or agent found in the workplace.

12. Provide the necessary engineering control design technology for closed systems, ventilation equipment, etc., for the various work sites where carcinogenic substances are employed.

13. Provide the necessary development, review, and certification of respirators and protective clothing for workers employed in areas using or producing carcinogenic substances.

14. Provide for the necessary research in developing sampling regimens and analytical methods necessary to properly identify carcinogenic substances as well as providing for the methodology to monitor the work environment for carcinogenic substances.

15. Stimulate occupational health and safety programs in State and local governments, and in industries.

Some of the Institute's specific objectives for 1977 include:

1. Completing criteria of 24 hazardous substances or harmful physical agents including carbon dioxide, fluorine phosgene, phosphine, and zinc chloride. The Institute will continue to complete development of criteria documents initiated in 1975 and 1976;

2. Publishing the seventh annual "Registry of Toxic Effects of Chemical Substances";

3. Testing and certifying more than 150 protective devices and industrial hygiene monitoring devices;

4. Providing response to an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivors eligibility for Black Lung benefits;

5. Completing approximately 70 health hazard determinations in response to requests from employers or authorized representatives of employees for determination of whether substances normally found in their place of employment have potentially toxic effects;

6. Processing approximately 30,000 coal miners' chest roentgenograms (X-rays);

7. Providing approximately 1,300 man-weeks of training on a fee-for-service basis;

8. Conducting industry-wide epidemiologic studies, research related to carcinogenic substances and other field studies. These include the North Carolina brick manufacturing industry study to evaluate the validity of "no disease" claims by the industry and the talc manufacturing study which includes tests to quantitate prevalence of chronic respiratory disease and lung cancer;

9. Stimulate occupational health and safety programs in State and local governments, and in industries.

The 1977 request provides for an increase over the 1976 request of $574,000 for mandatory items such as annualization of 1976 pay increase, annualization of positions new in 1976, within grade increases, postage increase, increase in utility rates, and an increase in the HEW Working Capital Fund and the PHS Service and Supply Fund. The decrease of 2 positions in 1977 are related to the elimination of the Training Grant Program.

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Buildings and facilities .. | --- | $3,156,000 | --- | $4,612,000 | --- | --- | --- | -$4,612,000 |

---

The Buildings and Facilities Activity provides funds which remain available until expended for the construction, alteration and repair of buildings and facilities of, or used by, the Center for Disease Control, including the preparation of plans and specifications.

No new budget authority is requested in 1977. The $4,612,000 available in 1976 will be obligated during the year, resulting in a decrease of $4,612,000 in obligations in 1977.

In 1976 these funds will be used to plan a modern and safe facility at a suitable location for the research activities of the National Institute for Occupational Safety and Health.

| | 1976 Revised President's Budget | | 1976 Appropriation | | 1977 Estiamte | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Program management. | 264 | $10,989,000 | 264 | $10,439,000 | 264 | $10,989,000 | --- | +$550,000 |

The Center for Disease is the Nation's primary federal focus for an interrelated group of program activities directed at preventing diseases and their consequences. These funds will provide the executive direction and resource management staff necessary for planning, directing and evaluating all CDC program activities in 1977. 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 1977, 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.

The increase of $550,000 is for built-in increases for annualization of pay raise, within grade increases, and GSA rent; partially offset by one less day of pay.

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Disease Control

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 2,617 | $98,925,000 | Indefinite | 2,516 | $95,197,000 |

Purpose: Title III of the Public Health Service Act. 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 1976: Epidemiologic assistance was provided to various State health agencies during the largest and most geographically widespread outbreak of St. Louis encephalitis (SLE) ever recorded; approximately 1.8 million different determinations were made on specimens submitted by States and local health department laboratories; and the Center provided coordination for a national health education program.

Objectives for 1977: Grants will continue to be provided to assist States and localities to develop control measures for a number of sexually transmitted diseases other than syphilis and gonorrhea because of their increasing national significance; to support immunization programs; rat control projects in communities with the most severe rat problems; and lead based paint poisoning programs.

Surveillance of diseases of national significance, such as hepatitis, influenza, and others will be continued.

The Center will continue to expand its proficiency testing and on-site laboratory evaluation activities both in number of participating laboratories as well as numbers and types of constituents tested. Efforts will also be aimed at improving laboratory surveillance and developing pharmacy surveillance in hospitals and clinics.

Coordination of health education activities already underway in various agencies of the Department of Health, Education, and Welfare will be further developed.

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Occupational Health

| 1976 Estimate | | | 1977 Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | Authorization | Pos. | Amount |
| 773 | $39,533,000 | Indefinite | 771 | $37,107,000 |

Purpose: PHS Act as amended, Federal Coal Mine Health and Safety Act of 1969, and Occupational Safety and Health Act of 1970. 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 1976: (1) Thirty-four research grants in the amount of $1,900,000 were awarded in 1976; (2) fifty training grants in the amount of $3,000,000 were awarded to continue active grant supported training programs; (3) completed development of 24 criteria for occupational safety and health standards; (4) tested and certified more than 100 protective devices and industrial hygiene monitoring devices; and , (5) published the sixth annual "Registry of Toxic Effects of Chemical Substances".

Objectives for 1977: (1) Complete criteria of 24 hazardous substances or harmful physical agents; (2) publish the seventh annual "Registry of Toxic Effects of Chemical Substances"; (3) test and certify more than 150 protective devices and industrial hygiene monitoring devices; (4) provide response to an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivors eligibility for Black Lung benefits; and, (5) complete approximately 70 health hazard determinations.

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Buildings and Facilities

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $4,612,000 | Indefinite | --- | --- |

Purpose: Title III of the Public Health Service Act. These funds are for 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 1976: A contract will be let for the plans and specifications of a modern safe research facility for the National Institute for Occupational Safety and Health.

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Program Management

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 264 | $10,439,000 | Indefinite | 264 | $10,989,000 |

Purpose: Title III of Public Health Service Act. 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 1976: The necessary staff was provided to assure policy and program leadership and to monitor and evaluate progress in achieving ongoing program objectives. Payments for the Center's occupied building space were made under the Standard Level User's Charge system.

Objectives for 1977: Effective and efficient program direction, staff services, and regional office support for Preventive Health Services programs will be provided. Payments of Standard Level User Charges will be met.

New Positions Requested

| | 1977 | | |
|---|---|---|---|
| | Grade | Number | Annual Salary |
| Disease control | | | |
| Laboratory improvement | | | |
| Hematologist | GS-15 | 1 | $37,309 |
| Chemist | GS-14 | 2 | 53,722 |
| Public Health Advisor | GS-14 | 1 | 26,861 |
| Education Specialist | GS-13 | 1 | 22,906 |
| Public Health Analyst | GS-13 | 1 | 22,906 |
| Microbiologist | GS-12 | 1 | 19,386 |
| Chemist | GS-12 | 1 | 19,386 |
| Mathematical Statistician | GS-11 | 2 | 32,510 |
| Microbiologist | GS-11 | 2 | 32,510 |
| Medical Technologist | GS-9 | 11 | 148,302 |
| Microbiologist | GS-7 | 4 | 44,184 |
| Cytology Technologist | GS-7 | 2 | 22,092 |
| Histology Technologist | GS-7 | 1 | 11,046 |
| Chemist | GS-5 | 3 | 26,775 |
| Medical Technologist | GS-5 | 3 | 26,775 |
| Laboratory Technician | GS-5 | 5 | 44,625 |
| Microbiologist | GS-5 | 4 | 35,700 |
| Secretary | GS-5 | 2 | 17,850 |
| Clerk-Typist | GS-3 | 2 | 14,204 |
| Total new positions, all activities | | 49 | 659,049 |

Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Estimate | Transition Quarter |
| 1. Disease control: | | |
| a. Project grants | $41,400,000 | $6,500,000 |
| b. Disease investigations, surveillance, and control | 43,411,000 | 12,380,000 |
| c. Laboratory improvement | 10,601,000 | 3,054,000 |
| d. Health education | 3,513,000 | 753,000 |
| Subtotal | 98,925,000 | 22,687,000 |
| 2. Occupational health: | | |
| a. Grants | 4,900,000 | 475,000 |
| b. Direct operations | 34,633,000 | 8,570,000 |
| Subtotal | 39,533,000 | 9,045,000 |
| 3. Buildings and facilities | 4,612,000 | --- |
| 4. Program management | 10,439,000 | 2,800,000 |
| Total | 153,509,000 | 34,532,000 |

Explanation

The transition quarter budget represents funds to maintain the 1976 level of operation during the period July 1, 1976 - September 30, 1976. The total was based on 25 percent of the FY 1976 Budget Estimates.

WEDNESDAY, MARCH 3, 1976.

# ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

## WITNESSES

JAMES D. ISBISTER, ADMINISTRATOR
DR. ERNEST P. NOBLE, 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
DR. FRANCIS N. WALDROP, DEPUTY ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
JOSEPH R. LEONE, EXECUTIVE OFFICER, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
JOHN D. MAHONEY, DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
JOHN A. DEERING, ACTING DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLOOD. We have the high honor and great privilege of having with us the distinguished gentleman from the great State of Arkansas. We won't begin the formal testimony. Chairman Mills has someone he wants us to meet, I believe.

Mr. MILLS. Yes; I do.

Mr. Chairman, I wanted to come this morning because I was not certain that the members of the committee had had the opportunity which I have had recently of becoming acquainted with the new Director of NIAAA in the Department of HEW. Dr. Noble is a very eminent member of the medical profession from the State of California, and one that I am sure you will get to know quite well, and appreciate as I do. He is much interested in the problems of alcoholism as I am. And I hope the committee will listen to him with a great deal of care and attention.

Mr. FLOOD. It certainly won't hurt him that you have introduced him.

We will now begin the formal portion of our hearing on the Alcohol, Drug Abuse, and the Mental Health Administration. The presentation will be made by Mr. James D. Isbister, who is the Administrator. We have a biographical sketch of you, Mr. Isbister which we will place in the record. We will also include the biographies of your colleagues.

[The biographical sketches follow:]

BIOGRAPHICAL SKETCH OF JAMES DAVID ISBISTER

Home address: 9521 Accord Drive, Potomac, Maryland 20854.
Business address: Room 12–105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852. 443–4797
Born: March 31, 1937, Mt. Clemens, Michigan.
Married: Jenefir D. Wilkinson.

Children: Wendy Jill Isbister (born 1962). Kirstin Ann Isbister (born 1965).

Employment: 1975 to present—Administrator, Alcohol, Drug Abuse, and Mental Health Administration.

1974–75—Acting Administrator, Alcohol, Drug Abuse, and Mental Health Administration.

1973–74—Academic Visitor, London School of Economics and United Kingdom Medical Research Council.

1970–73—Deputy Director, National Institute of Mental Health.

1967–70—Executive Officer, National Institute of Mental Health.

1965–67—Executive Officer, National Library of Medicine.

1963–65—Assistant to the Assistant Secretary for Administration, Department of Health, Education, and Welfare.

1962–63—Management Analyst, National Institutes of Health.

1961–62—United States Air Force.

1960–61—Management Intern, National Institutes of Health.

1960—Management Assistant, Department of the Navy.

Education: 1942–54—Elementary and Secondary education in public schools of Michigan.

1954–58—University of Michigan (Bachelor of Arts with honors and distinction, 1958).

1958–59—Princeton University.

1960–66—George Washington University, part-time study of Business and Public Administration (Masters of Arts, 1966).

Honors, fellowships, and awards: 1954–58—University of Michigan Regents—Alumni Honor Award.

1954–58—Ethyl Kilham Modern Language Scholarship.

1955—Oreon Scott Prize.

1958—Kappa Sigma National Scholarship—Leadership Award.

1958–59—National Woodrow Wilson Fellowship.

1960–61—George Washington University Scholarship.

1964—Quality performance award, Department of Health, Education, and Welfare.

1966—William A. Jump Foundation Meritorious Award for Exemplary Performance in Public Administration.

1969—Superior Service Award, Department of Health, Education, and Walfare.

1973—Distinguished Service Award, Department of Health Education, and Welfare.

BIOGRAPHICAL SKETCH OF ERNEST P. NOBLE

Born: April 2, 1929, Baghdad, Iraq.

Citizenship: U.S.A.

Marital Status: Married, three children.

Education: Rutgers University, New Brunswick, 1947–49, Chemistry. University of California, Berkeley, B.S., 1951, Chemistry. Oregon State University, Corvallis, Ph.D., 1955, Biochemistry. Sorbonne, Paris, France, Post-Doctoral, 1956, Biochemistry. Case Western Reserve University, Cleveland, Post-Doctoral, 1957, Biochemistry. Case Western Reserve University, Cleveland, M.D., 1962, Medicine.

Professional and Research Experience: 1971—Professor, Departments of Psychiatry and Human Behavior, Psychobiology, and Medical Pharmacology and Therapeutics, and Chief of Neurochemistry in the Department of Psychiatry and Human Behavior, University of California, Irvine.

1970—Graduate Advisor, College of Medicine, University of California, Irvine.

1970–71—Associate Professor, Departments of Psychobiology and Medical Pharmacology and Therapeutics, University of California, Irvine.

1969—Medical Attending Staff, Orange County Medical Center, Orange, Ca.

1969–71—Associate Professor and Chief of Neurochemistry, Department of Psychiatry and Human Behavior, University of California, Irvine.

1966—Visiting Scientist, National Institute of Mental Health, May 1 to October 1, with Dr. Julius Axelrod (Nobel Laureate).

1966–69—Career Development Awardee, National Institute of Mental Health, NIH.

1965–69—Assistant Professor, Department of Psychiatry, Stanford University School of Medicine.

1963–65—Research Associate and USPHS Post-Doctoral Fellow, Department of Psychiatry, Stanford University School of Medicine.

1963–66—Resident in Psychiatry, Stanford University School of Medicine and Palo Alto-Stanford Hospital.

1962–63—Intern, Palo Alto-Stanford Hospital, Palo Alto, Ca.

1957–62—Senior Instructor, Department of Medicine, Case Western Reserve University, Cleveland.

Honors: Phi Lambda Upsilon 1953 (National Chemistry Honorary). Sigma Xi, 1955. Fulbright Scholar, 1955–56. Research Career Development Award, NIMH, 1966–69. Member: Alcoholism and Alcohol Problems Review Committee, NIMH, 1969–73. Member: Task Force for the First Special Report to the U.S. Congress on Alcohol and Health, 1971. Member: Research Task Force for the National Institute of Mental Health for Research in the Service of Mental Health, 1972–74. Member: NIAAA Intramural Research Task Force, 1973. Guggenheim Fellow, 1974–75.

Societies: New York Academy of Sciences; Society for Experimental Biology and Medicine; American Association for the Advancement of Science; American Psychiatric Society; Psychiatric Research Society; American Medical Society on Alcoholism; American College of Neuropsychopharmacology, Fellow; and International Society for Neurochemistry, Member.

Editorial Boards: Journal of Neuroscience Research. Alcohol Research, Journal of American Medical Society on Alcoholism, Co-Chief Editor.

Committees of the College of Medicine Faculty (elected): Member, Graduate Council (Committee on Graduate Academic Programs, 1969–1972. Chairman, Graduate Council, 1970–71; 1971–1972. Member, Executive Committee, 1970–71; 1971–72. Member, Curriculum & Educational Policy Committee, 1975–78.

Dean's Advisory Committees (appointed): Member, Cardiovascular Coordinating Committee, 1969–79; Member, Animal Care Committee, 1969–70; Member, Research Travel, 1972–73; and Member, UCI–CCM Research Committee, 1973–75. Planning Committee for Medical Sciences Bldg. I, 1973–75.

Departmental Committees: Executive Faculty Committee, 1969—Coordinating Committee for Research Training, 1972–73. Graduate Training Committee, 1972–73.

University: Ad Hoc member, Faculty Promotions, 1971–75.

PUBLICATIONS—PAPERS


Gilmour, C. M., Butterworth, E. M., Noble, E. P., and Wang, C. H., Studies on the biochemistry of the Streptomyces. I. Terminal oxidative metabolism in *Streptomyces griseus*. *J. Bact., 69:* 719, 1955

Noble, E. P., Legault-Demare, J., and Jutisz, M., Absence de groupement C-terminal libre dans l'ovomucoide. *Bull. Soc. Chim. Biol., 39:* 1077, 1957.

Noble, E. P., Reed, D. R., and Wang, C. S., Utilization of acetate, pyruvate, and $CO_2$ by *Penicillium digitatum*. *Canad. J. Microbiol., 4:* 469, 1958.

Noble, E. P., Stjernholm, R. L., tand Weisberger, A. S., Carbohydrate metabolism in leukocytes. I. The pathway of 2- and 3-carbon compounds in the rabbit polymorphonuclear leugocyte. *J. Biol. Chem. 235:* 1262, 1960.

Noble, E. P., and Weisberger, A. S., The *in vivo* tumor inhibitory activity of normal human serum. *Proc. Soc. exp. Biol. Med., 105:* 270, 1960.

Stjerholm, R. L., and Noble, E. P., Carbohydrate metabolism in leukocytes. II. The pathway of ribose and xylose metabolism in the rabbit polymorphonuclear leukocyte, *J. Biol. Chem., 236:* 614, 1960.

Noble, E. P., Amethoptern. Purification of 4-amino-$N^{10}$-methyl pteroyl-L-glutamic acid. In A. Meister (ed.), *Biochemical Preparations*, Vol. 8, John Wiley and Sons, Inc., New York, 1961, pp. 20.

Noble, E. P., Stjernholm, R. L., and Ljungdahl, L., Carbohydrate metabolism in leukocytes. III. Carbon dioxide incorporation in the rat polymorphonuclear leukocytes. *Biochem. Biophys. Acta, 49:* 593, 1961.

Stjernholm, R. L., and Noble, E. P., Carbohydrate metabolism in leukocytes. IV. The metabolism of glucose in polymorphonuclear leukocytes from rabbit. *J. Biol. Chem., 236:* 3093, 1961.

Weisberger, A. S., and Noble, E. P., Abnormal globin formation in human megaloblasts. *Nature, 192:* 1261, 1961.

Noble, R. E., Koch-Weser, D., and Noble, E. P., Glucose metabolism by *Mycobacterium smegmatis*. Evidence for the pentose cycle. *The Amer. Rev. Dis., 86:* 391, 1962.

Stjernholm, R. L., and Noble, E. P., Carbohydrate metabolism in leucocytes. V. The metabolism of five-carbon substrates in polymorphonuclear leucocytes of rabbit. *Archives Biochem. Biophysica 100:* 200, 1963.

Lauryssens, M., Stjernholm, R., and Noble, E. P., Comparison (*in vivo*) du métabolisme des hydrates de carbone dans le foile des rats normaux et dans le foie rats rendus diabétiques par l'alloxane. *Arch. Internat. Physiol. Biochim. 71:* 132, 1963.

Lauryssens, M., Noble, E. P., and Stjernholm, R., Le métabolism du propionate dans les leucocytes. *Arch. Internat. Physiol. Biochim., 71:* 636, 1963.

Esmann, V., Noble, E. P., and Stjernholm, R. L., Carbohydrate metabolism in leukocytes. VI. The metabolism of mannose and fructose in polymorphonuclear leukocytes of rabbit. *Acta Chem. Scand., 19:* 1672, 1965.

Kopell, B. S., Noble, E. P., and Silverman, J., The effect of Thiamylal and Methamphetamine on the two-flash threshold. *Life Sciences, 4:* 2211, 1965.

Noble, E. P., Wurtman, R. J., and Axelrod, J. A., A simple and rapid method for injecting $H^3$-norepinephrine into the lateral ventricle of the rat brain. *Life Sciences, 6:* 281, 1967.

Wurtman, R. J., Noble, E. P., and Axelrod, J., Inhibition of enzymatic synthesis of epinephrine by physiological doses of glucocorticoids. *Endocrinology, 80:* 825, 1967.

Parker, L. N., and Noble, E. P., Prenatal glucocorticoid administration and the development of the epinephrine-forming enzyme. *Proc. Soc. Exp. Biol Med., 126:* 734, 1967.

Brown, B. M., and Noble, E. P., Cycloheximide and learning in the isolated cockroach ganglion. *Brain Res., 6:* 363, 1967.

Brown, B. M., and Noble, E. P., Cycloheximide, amino acid incorporation and learning in the isolated cockroach ganglion. *Biochem. Pharmacol., 17:* 2371, 1968.

Eng, L. F., and Noble, E. P., The maturation of rat brain myelin. *Lipids, 3:* 157, 1968.

Noble, E. P., Silbergeld, S., Kopell, B., McKinney, W., Wittner, W. K., and Butte, J. C. The effects of physiological doses of corticosteroid on catecholamine metabolism in man. *J. Psychiat. Res., 6:* 159, 1968.

Kakihana, R, Butte, J. C., and Noble, E. P., Effects of goldthioglucose on alcohol consumption in C57BL mice. *Life Sciences, 7:* 825, 1968.

Kakihana, R., Noble, E. P., and Butte, J. C., Corticosterone response to ethanol in inbred strains of mice. *Nature, 218:* 360, 1968.

Butte, J. C., and Noble, E. P., Simultaneous determination of plasma or whole blood cortisol and corticosterone. *Acta Endocr. 61:* 678, 1969.

Noble, E. P., Butte, J. C., and Kakihana, R., A test for alcholism? *Lancet* (London), 7/12/69 : 107, 1969.

Stjernholm, R. L., Noble, E. P., Dimitrov, N. V., Morton, D. J., and Falor, W. H., Carbohydrate metabolism in leukocytes. XII. Metabolism of the human lymphocyte. *J. Reticuloendothel. Soc., 6:* 590, 1969.

Stjernholm, R. L., Noble, E. P., Dimitrov, N. V., Kellermeyer, R. W., and Falor, W. H., Differentation of normal and leukemic leukocytes into three groups by propionate metabolism. *J. Reticuloendothel. Soc., 8:* 446, 1970.

Hollister, L. E., Moore, F., Kanter, S., and Noble, E. P., $\Delta^9$-tetrahydrocannabinol, Synhexyl and marijuana extract administered orally in man : Catecholamine excretion, plasma cortisol levels and platelet serotonin content. *Psychopharmacologia, 17:* 354, 1970.

Silbergeld, S., Brast, N., and Noble, E. P., The menstrual cycle: A doubleblind study of symptoms, mood and behavior, and biochemical variables using Enovid and placebo. *Psychosomat. Med., 33:* 411, 1971.

Tewari, S., and Noble, E. P., Ethanol and brain protein synthesis. *Brain Res., 26:* 469, 1971.

Noble, E. P., Kakihana, R., and Butte, J. C., Corticosterone metabolism in alcohol-adapted mice. In *Biological Aspects of Alcohol*, Roach, M. K., McIsaac, W. M., and Creaven, P. J. (eds.), University of Texas Press, Austin, pp. 389–417, 1971.

Kakihana, R., Butte, J. C., Hathaway, A., and Noble, E. P., Adrenocortical response to ethanol in mice: Modification by chronic ethanol consumption. *Acta endocr., 67:* 653, 1971.

Noble, E. P., Ethanol and adrenocortical stimulation in inbred mouse strains. *In Recent Advances in Studies of Alcoholism*, Mello, N. K., and Mendelson, J. H. (eds.), U.S. Government Printing Office, Washington, 1971, pp. 72–106.

Tewari, S., and Noble, E. P., Chronic effects of ethanol on brain protein sythesis. In *Recent Advances in Studies of Alcoholism.* Mello, N. K., and Mendelson, J. H. (eds.), U. S. Government Printing Office, Washington, 1971, pp. 107–122.

Noble, E. P., and members of a Task Force, In *Alcohol and Health*, a report to Congress from the Secretary of the U.S. Department of Health Education, and Welfare. U. S. Government Printing Office, Washington, 1971.

Noble, E. P., Effects of chronic ethanol ingestion by mice on brain protein and RNA metabolism. In Proceedings *Workshop on Alcoholic Blackout.* St. Thomas, Virgin Islands, March 23–24. National Institute of Alcohol Abuse and Alcoholism, NIMH, 1972, pp. 91–92B.

Noble, E. P., and Tewari, S. The effects of chronic ethanol ingestion on the protein synthesizing system of C57BL/6J mice. In *Biological Aspects of Alcohol Consumption.* Forsander, O., and Eriksson, K. (eds.), The Finnish Foundation for Alcohol Studies, Vol. 20 :275–287, 1972.

Butte, J. C., Kakihana, R., and Noble, E. P., Rat and mouse brain corticosterone, *Endocrinology 90* :1091, 1972.

Gottschalk, L. A., Noble, E. P., Stolzoff, G. E., Bates, D. E., Cable, C. G, Uliana, R. L., Birch, H., and Fleming, E. W. Relationship of chlordiazepine blood levels to psychological and biochemical responses. In *Benzodiazepines.* Garattini, S., Mussini, E., and Randall, L. O. (eds.), Raven Press, New York, 1973, pp. 257–283.

Noble, E. P., Alcohol and the adrenocortical function of animals and man. In *Alcoholism: Progress in Research and Treatment.* Bourne, P. G., and Fox, R. (eds.), Academic Press, New York, 1973, pp. 105–135.

Noble, E. P., and Tewari, S., Protein and ribonucleic acid metabolism in brains of mice following chronic alcohol consumption. *Ann. N.Y. Acad. Sci., 215:* 333, 1973.

Silbergeld, S., and Noble, E. P., Corticosteroids in psychiatric patients: Sabacute and diurnal effects on free fatty acid and catecholamine metabolism. *J. Psychiatric Res. 10:* 59, 1973.

Butte, J. C., Kakihana, R., Farnham, M. K., and Noble, E. P., The relationship between brain and plasma corticosterone stress response in developing rats. *Endocrinology 92:*1775, 1973.

Gottschalk, L. A., Noble, E. P., and Elliott, H., Preliminary studies of relationships betwen psychoactive drug blood levels and clinical responses: Chloridazeopxide, Meperidine, and Thioridazine. *Psychopharmacology Bull. 9:* 40, 1973.

Noble, E. P., and Tewari, S., Protein and ribonucleic acid metabolism in brains of mice following chronic alcohol consumption. Symposium on Neurochemistry, Academy of Sciences of Armenia SSR, 1972. In *Problems of Biochemistry,* Vol. 8, 1973, pp. 317–330.

Dinovo, E. C., Gottschalk, L. A., Noble, E. P., and Biener, R., Isolation of a possible metabolite of thioridazine and mesoridazine from human plasma. *Res Comms. Chem. Path. Pharmacol. 7:* 487, 1974.

Syapin, P. J., Tewari, S., and Noble, E. P., Effects of chronic ethanol ingestion on microtubular protein of mice brains. *Proc. West. Pharmacol. Soc. 17:* 184, 1974.

Noble, E. P., White Paper to the National Institute on Alcohol Abuse and Alcoholism on Feasibility Study on Treatment of Acute Inebriation, 1974.

Dinovo, E. C., Gottschalk, L. A., Noble, E. P., and Biener, R., Isolation of a possible new metabolite in human plasma following thioridazine and mesoridazine administration. *Proc. West. Pharmacol. Soc. 17:*110, 1974.

Parker, E. S., Alkana, R. L., Birnbaum, I. M., Eichner, J. T., and Noble, E. P., Alcohol and the disruption of cognitive processes. *Arch Gen. Psychiatry 31:*824, 1974.

Noble, E. P., Testing for a "sobering pill", Department of Transportation, Contract No. DOT–HS–253–3–744, December, 1974.

Smith, R. C., Parker, E. S., and Noble, E. P., Alcohol and affect in dyadic social interaction. *Psychosomat. Med. 37:*25, 1975.

Fleming, E. W., Tewari, S., and Noble, E. P., Effects of chronic ethanol ingestion on brain aminoacyl-tRNA synthetases and tRNA. *J. Neurochem. 24:* 553, 1975.

Tewari, S., Fleming, E. W., and Noble, E. P., Alterations in brain RNA metabolism following chronic ethanol ingestion. *J. Neurochem. 24:*561, 1975.

Gruenke, L. D., Craig, J. C., Dinovo, E. C., Gottschalk, L. A., Noble E. P., and Biener, R., Identification of a metabolite of thioridazine and mesoridazine from human plasma. *Res. Comm. Chem. Path. Pharm. 10:*221, 1975.

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Tewari, S., and Noble, E. P., Chronic ethanol ingestion by rodents: Effects on brain RNA. In *Alcohol and Abnormal Protein Biosynthesis: Biochemical & Clinical.* Rothschild, M. A., Ortaz, M., and Schreiber, S. S. (eds.), Pergamon Publishing Company, pp. 421–448. 1975.

Noble, E. P., Alkana, R. L., and Parker, E. S., Ethano induced CNS depression and its reversal: A review, *Biomedical Research in Alchol Abuse Problems*, Canadian Department of National Health and Welfare. pp. 308–378. 1975.

Gottschalk, L. A., Biener, R., Noble, E. P., Birch, H., Wilbert, D. E., and Heiser, J. F., Thioridazine plasma levels and clincial response. *Compr. Psychiat. 16*:323, 1975.

Gottschalk, L. A., Dinovo, E., Biener, R., Birch, H., Syben, M., and Noble, E. P., Plasma levels of mesoridazine and its metabolites and clinical response in acute schizophrenia after a single intramuscular drug dose. *Psychopharmacol Bull 11*:33–34, 1975.

Noble, E. P., and Tewari, S., Ethanol and brain ribosomes, *Federation Proceedings 34*:1942, 1975.

Tewari, S. and Noble, E. P., Alteration in cerebral polynucleotide metabolism following chronic ethanol ingestion. In *Alcohol Intoxication and Withdrawal: Experimental Studies, II.* Gross, M. M. (ed.), Advances in Experimental Medicine and Biology, Vol. 59, Plenum Press, New York, 1975, pp. 37–53.

Noble, E. P., Alkana, R. L., and Parker, E. S., Ethanol induced CNS depression and its reversal: A review, *Proceedings 4th Annual Alcoholism Conference*, June 11–14, 1974. U.S. Government Printing Office, Washington, D.C., 1975, pp. 134–170.

Smith, R. C., Parker, E. S., and Noble, E. P., Alcohol's effects on some formal aspects of verbal social communication. *Arch. Gen. Physchiatry 32:* 1394, 1975.

Massarelli, R., Syapin, P. J., and E. P. Noble, Increased uptake of choline by neutral cell cultures chronically exposed to ethanol. *Life Sci. 18:* 397, 1976.

Noble, E. P., and Tewari, S., Metabolic aspects of alcoholism in the brain. In *Metabolic Aspects of Alcoholism.* Lieber, C. (ed.), Medical and Technical Publishing Co., Lancaster, England. In press, 1976.

Gottschalk, L. A., Dinovo, E., Biener, R., Birch, H., Syben, M., and Noble, E .P., Plasma levels of mesoridazine and its metabolites and clinical response in acute schizophrenia after a single intramuscular drug dose. In *Pharmacokinetics, Physchoactive Drug Blood Levels and Clinical Response.* Gottschalk, L. A., and Merlis, S. (eds.), Spectrum Publications, Inc., New York, In press, 1976.

Butte, J. C., Noble, E. P., and Kakihana, R., Circadian rhythm of cortico-sterone levels in rats. *Endocrinology*, In press, 1976.

Noble, E. P., Gillies, R., Vigran, R., and Mandel, P., The modification of the ethanol withdrawal syndrome in rats by di-*n*-propylacetate, *Psychopharmacologia*, In press, 1976.

Noble, E. P., Effects of ethanol on central nervous system cells. In *Proceedings of Behavioral Neurochemistry Symposium.* Madrid. In press, 1976.

Dinovo, E. C., Gruber, B., and Noble, E. P., Ethanol induced alterations in the exposure of sulfhydryl groups of rat brain microsomes, *Biochem. Biophys. Res. Comms.*, In press, 1976.

Syapin, P. J., Stefanovic, V. Mandel, P., and Noble, E. P., The chronic and acute effects of ethanol on adenosine triphosphatase activity in cultured astroblast and neuroblastoma cells, *J. Neuroscience Res.*, In press, 1976.

Noble, E. P., Syapin, P. J., Vigran, R., and Rosenberg, A., Neuraminidase-releasable sialic acid of cultured astroblasts exposed to ethanol, *J Neuroscience Res.*, In press, 1976.

Parker, E. S., Alkana, R. L., and Noble, E. P., Stress response in alcoholics and nonalcoholics, Submitted for publication, 1976.

ABSTRACTS

Wang, C. H., Reed, D. J., Noble, E. Christensen, B. E. and Cheldelin, V. H., Carbohydrate metabolism in *Penicillium digitatum. Fed. Proc., 16:* 226, 1957.

Noble, E. P., Stjernholm, R. L., and Weisberger, A. S., Distribution of C14 in glycogen glucose of rabbit polymorphonuclear leukocytes. *Fed. Proc., 18:* 294, 1959.

Stjernholm, R. L., Noble, E. P., and Weisberger, A. S., Distribution of Carbon-14 in glycogen of rabbit polymorphonuclear leukocytes after incubation with labeled pentose. 136th National American Chemical Society meeting, Atlantic City, 1959, p. 28C.

Noble, E. P. and Stjernholm, R.L., Carbon dioxide fixation in the rabbit polymorphonuclear Leukocytes. 137th National American Chemical Society meeting, Cleveland, 1960, p. 46C.

Stjernholm, R. L., and Noble, E. P., Glucose and galactose metabolism in rabbit polymorphonuclear leukocytes. *Fed. Proc., 19:* 82, 1960.

Noble, E. P., and Weisberger, A. S., Tumor inhibition with human serum. *Modern Medicine, 29:* 169, 1961.

Noble, E. P., Stjernholm, R. L. and Weisberger, A. S., Carbohydrate metabolism in lymphocytic leukemia leukocytes. *Blood, 17:* 361, 1961.

Noble, R. E., Koch-Weser, D., and Noble, E. P., Intermediate pathways of glucose Metabolism in Mycobacterium smegmatis. National Tuberculosis Association annual meeting, Cincinnati, 1961, p. 14.

Noble, E. P., Stjernholm, R. L., and Weisberger, A. S., The metabolism of 5-carbon substrates in rabbit polymorphonuclear leukocytes. Fifth International Congress of Biochemistry, Moscow, 1961, p. 379.

Noble, E. P., and Stjernholm, R. L., The role of some carboxylic acids in the metabolism of polymorphonuclear leukocytes. 141st National American Chemical Society meeting, Washington, 1962, p. 29C.

Noble, E. P., Stjernholm, R. L., and Clayton, R. B., Glutamate biosynthesis in the one day old rat. *Fed. Proc., 74:* 471, 1965.

Rossman, K. and Noble, E. P., Development of catecholamine chain enzymes in the growing rat. American Association for the Advancement of Science, Berkeley, 1965, p. 214.

Eng., L. F., Noble, E. P. and Kok, T., Composition of brain lipids and myelin during maturation. Western Federation of Neurological Sciences, San Francisco, 1966.

Tewari, S. and Noble, E. P., Chronic ethanol ingestion and its effects on brain RNA and protein synthesis. *Fed. Proc.*, 30: 495, 1971.

Gottschalk, L. A., Noble, E. P., Stolzoff, G. E., Bates, D. C., Cable, C. G., Uliana, R. L., Birch, H., and Fleming, E. W., Relationship of chlordiazepoxide blood levels to psychological and biochemical responses. 5th World Congress in Psychiatry, Mexico City, December 1971.

Tewari, S. and Noble, E. P., Ethanol and RNA metabolism in mouse brain. *Fed. Proc., 31:* 580, 1972.

Noble, E. P., Biochemical and physiological characteristics of alcohol and other abused depressant drugs. 20th International Congress of Psychology, Tokyo, August 1972.

Noble, E. P., Biological effects of alcohol and depressant drugs. 80th Annual Convention, American Psychological Assoc., Honolulu, September, 1972.

Tewari, S., Syapin, P., and Noble, E. P., Alcohol and brain proteins of mouse. *Fed. Proc., 32:* 598, 1973.

Noble, E. P., Parker, E., Alkana, R., Cohen, H., and Birch, H., Propranololethanol interaction in man. *Fed. Proc., 32:* 724, 1973.

Gottschalk, L. A., Biener, R., and Noble, E. P., Thioridazine plasma levels and clinical response. American Psychiatric Assoc., Honolulu, May, 1973.

Noble, E. P., Parker, E., Alkana, R. L., Cohen, H. B., and Birch, H., Propranolol and alcohol-induced changes in man. American Psychiatric Assoc., Honolulu, May, 1973.

Parker, E. S., Alkana, R. L., and Noble, E. P., Affective dynamics under stress: An experimental study of alcoholics and nonalcoholics. North American Congress on Alcohol and Drug Problems, San Francisco, December, 1974.

Gottschalk, L. A., Biener, R., Birch, H., Syben, M., and Noble, E. P., Plasma levels of mesoridazine and its metabolite after a single intramuscular dose and clinical response in acute schizophrenia. American College of Neuropsychopharmacology, San Juan, December, 1974.

Tewari, S. and Noble, E. P., Ethanol and poly U-dependent cerebral protein synthesis. *Fed. Proc., 34:* 224, 1975.

Gottschalk, L. A., Dinovo, E., Biener, R., Noble, E. P., and Birch, H., Pharmacokinetics of chlordiazepoxide, meperidine, thioridazine and mesoridazine and clinical response. American Psychiatric Association, 128th Annual meeting, Scientific Proceedings #170, 1975, pp. 164–165.

Tewari, S. and Noble, E. P., Ethanol and brain RNA metabolism. Pacific Slope Biochemical Conference, Honolulu, June, 1975, p. 65.

Noble, E. P., Massarelli, R., and Syapin, P. J., The acute and chronic effects of ethanol on glial and neuronal cells in tissue culture. 6th International Congress of Pharmacology, Helsinki, July, 1975, p. 243.

Tewari, S. and Noble, E. P., Alterations in protein synthesis of cerebral mitochondria following long-term ingestion of ethanol. 5th International meeting, International Society of Neurochemistry, Barcelona, September, 1975, p. 292.
Syapin, P. J., Stefanovic, V., Cieselski Treska, J., Mandel, P., and Noble, E. P., The effects of ethanol on growth and no ecto-enzymatic activity of cultured cells. 5th International meeting, International Society of Neurochemistry, Barcelona, September, 1975, p. 232.
Noble, E. P., Syapin, P. J., Vigran, R., Gombos, G., Vincendon, G., and Rosenberg, A., The effects of ethanol on neuraminidase releasable sialic acid of cultured neural cells. 5th International meeting, International Society of Neurochemistry, Barcelona, September, 1975, p. 218.

BIOGRAPHICAL SKETCH OF BERTRAM S. BROWN

Date and Place of Birth: Brooklyn, New York—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 Mass.; Director of Psychiatry, Norfolk Prison Colony.

April 1960 to Present—U.S. Public Health Service, National Institute of Mental Health: 1. Staff Psychiatrist, Mental Health Study Center, April 1, 1960 to July 4, 1961; 2. Special Assistant for Program Extramural Programs, July 5, 1961 to October 14, 1963; 3. Special Assistant for Program Office of the Director, October 15, 1963 to March 22, 1964; 4. Chief, Community Mental Health Facilities Branch, March 23, 1964 to June 5, 1966; 5. Associate Director for Mental Health Service Programs, June 9, 1966 to December 31, 1966; 6. Deputy Director, National Institute of Mental Health, January 1, 1967 to June 2, 1970; 7. Director, National Institute of Mental Health, June 3, 1970 to present.

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. 1960–61—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 1962–72—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.

BIOGRAPHICAL SKETCH OF ROBERT L. DUPONT

Born: March 25, 1936 (Toledo, Ohio).

Current full time position: Director, National Institute on Drug Abuse, Department of Health, Education and Welfare, 11400 Rockville Pike, Rockville, Maryland 20852. (301) 443–6565.

Education: June 1963—M.D., Harvard Medical School, Boston, Massachusetts. June 1958—B.A., Emory University, Atlanta, Georgia. June 1954—Graduated from East Denver High School.

Post-graduate training: 1966–68—Clinical Associate; Laboratory of Clinical Sciences, National Institute of Mental Health, Bethesda, Maryland.

1964–66—Psychiatric Resident and Teaching, Fellow in Psychiatry, Massachusetts Mental Health Center, Harvard Medical School, Boston, Massachusetts.

1963–64—Medical Intern, Cleveland Metropolitan General Hospital, Western Reserve Medical School, Cleveland, Ohio.

Chronology of Employment: 1973 to present—Director, National Institute on Drug Abuse, Department of Health, Education, and Welfare, Rockville, Maryland.

1973–75—Director, Special Action Office for Drug Abuse Prevention, Executive Office of The President, Washington, D.C.

1974–(2 months)—Acting Administrator, Alcohol, Drug Abuse and Mental Health Administration, Department of Health, Education and Welfare, Rockville, Maryland.

1970–73—Administrator, Narcotics Treatment Administration, Department of Human Resources, Government of the District of Columbia, Washington, D.C.

1968–70—Research Psychiatrist and, Acting Associate Director for Community Services, District of Columbia Department of Corrections, Washington, D.C.

1965–66—(part time)—Senior Psychiatrist, Massachusetts Department of Corrections, Norfolk Prison, Norfolk, Massachusetts.

1964–65—(part time)—Psychiatrist, Washington Hospital, Jamaica Plains, Massachusetts.

1961—(3 months)—Research Assistant, Tuberculosis Laboratory, Communicable Disease Center, Atlanta, Georgia.

1959—(2 months)—Epidemiology Trainee, California Department of Public Health, Berkeley, California.

Consultanships and board memberships: 1974–present—Member, Coordinating Council on Juvenile Justice and Delinquency Prevention, Executive Office of The President, Washington, D.C.

1972–present—Member, Board of Directors, Washington Society for the Performing Arts.

1972–present—Member, Advisory Committee, Washington Junior League, 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.

1972–73—Member, National Advisory Council on Drug Abuse Prevention, A Presidential Appointment, Washington, D.C.

1971–73—Consultant, Veterans Administration, Washington, D.C.

1971–73—Consultant to the Special Action Office for Drug Abuse Prevention, The White House, Washington, D.C.
1971–73—Member, Board of Directors, Center for Correctional Justice, Washington, D.C.
1971–73—Consultant to the Food and Drug Administration, Bureau of Drugs, Rockville, Maryland.
1971–72—Member, The Armed Forces Epidemiological Board, Committee on Drug Abuse, Washington, D.C.
1971–72—Consultant, Special Committee on Crime Prevention and Control, American Bar Association, Washington, D.C.
1968–71—Consultant, Child Research Branch, National Institute of Mental Health, Bethesda, Maryland.
1967–68—Consultant on Research and Development, District of Columbia Department of Corrections, Washington, D.C.
Faculty appointments: 1972–present—Associate Clinical Professor of Psychiatry and Behavioral Sciences, George Washington Medical School.
1970–72—Assistant Clinical Professor of Psychiatry, George Washington University Medical School.
1964–66—Teaching Fellow in Psychiatry, Harvard Medical School.
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, Maryland.
Societies: District of Columbia Medical Society; Washington Psychiatric Society; Washington Area Council on Alcoholism and Drug Abuse; American Psychiatric Association (Fellow); 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.
Medical license: District of Columbia; Maryland; Massachusetts; California.
Certification: Certified in Psychiatry by the American Board of Psychiatry and Neurology, 1970.

Mr. FLOOD. You have some people with you.

Mr. ISBISTER. I would like to introduce several members of our Administration who are here. Most of them are well known to you and to the committee. First, the Deputy Administrator of our agency, Dr. Neil Waldrop. Dr. Noble you have met. You know Dr. Brown very well, the Director of the National Institute of Mental Health. You know Dr. DuPont, the Director of the National Institute on Drug Abuse. To my left is Mr. John Mahoney, who is the Director of our Division of Financial Management; also Mr. Charles Miller.

PREPARED STATEMENT

Mr. FLOOD. Mr. Isbister, I see you have a prepared statement here. How would you like to handle this?

Mr. ISBISTER. I would like to submit it for the record, Mr. Chairman.

Mr. FLOOD. Yes; we will do that.

[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 Institutes 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.

Gratifying inroads have been made on these diseases, and the promise of further advancements in the foreseeable future is genuine. Nonetheless, alcoholism, drug abuse, and mental illness are crippling realities for millions of Americans and their families and a great burden to our economy. The relief of this pain and this burden calls for our continued dedication and effort.

There are about 9 million alcoholic men and women in the country today. Each year we count more than 25,000 alcohol-related traffic fatalities; 15,000 alcohol-related homicides and suicides; 20,000 deaths from alcohol-related disease; 20,000 fatalities due to alcohol-related accidents; and two million arrests each year for simple public drunkenness. One out of every 10 members of the Nation's work force is an alcoholic or a serious alcohol abuser. Alcohol abuse not only brings suffering to individuals and families and wastes vast human potential; it also exerts a heavy financial drain on the country, a drain recently estimated at $25 billion a year.

Drug abuse no longer can be thought of as a phenomenon restricted to lower socioeconomic groups and inner city ghettoes. Four major national surveys recently indicated that drug abuse, like alcoholism, indiscriminately affects every segment of the American population.

The surveys show that 6 percent of adult American males aged 20 to 30 have experimented with heroin. Fifty-three percent of all 18- to 25-year-olds have experimented with marihuana. Thirteen percent of the adult public and 10 percent of young people have reported nonmedical experience with tranquilizers, sedatives, stimulants, and over-the-counter drugs. Over 3 percent of youth and adults have experimented with cocaine, and since 1972 cocaine use among youth has increased over 140 percent. The economic and social cost of illicit drug use is more than $10 billion yearly.

One in ten of our citizens—or approximately 20 million Americans—suffers from some form of mental or emotional illness, and there are more patients in hospitals receiving treatment for mental disorders than for any other illness.

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 signs of depression. And, more than 2 million Americans alive today will experience some degree of disruption in their lives as a result of schizophrenia. We estimate that this constellation of problems costs the Nation close to $40 billion annually.

I am gratified to say that we are making progress in our programs to deal with this broad spectrum of human problems and their impact on our national well-being. We nevertheless have a long, long way to go.

In my report to you today, I propose to describe progress to date and our programs and plans by dealing briefly with each of the three ADAMHA Institutes.

First, however, I would like to touch on some major features of the proposed fiscal year 1977 budget—features which affect more than one of the Institutes and, in two cases, all three.

Research was the original and, for a long time, the sole mission of the National Institute of Mental Health, the agency from which ADAMHA evolved. Today the importance of research remains unchanged. It is our basic philosophy that research activities should be and are the highest priority of the agency. In terms of both economics and ultimate results, a strong research program is the best investment that can be made in promoting our primary goals.

In training, the budget proposes the phaseout of clinical and research training grant activities, and predoctoral research training fellowship awards throughout the agency, but allows for continued support of postdoctoral fellowships and a National Drug Abuse Training Center.

In conformance with the Administration's goals of consolidating the Federal support of a number of health programs, the budget proposes that the funding for community mental health centers and alcoholism treatment programs be consolidated into a new State block grant program to provide the States and local communities with greater flexibility in adapting health care funds to their specific needs.

I should now like to report on the Institutes individually.

A priority of the National Institute on Alcohol Abuse and Alcoholism has been to make effective treatment available through direct funding of treatment programs and through formula grants to the States. Recently, results of the first large-scale followup study of clients treated by NIAAA-funded centers indicated that 70 percent showed a measure of success 18 months after intake.

Within its treatment efforts, the Institute assigns a high priority to occupational alcoholism programs. Alcoholism often can be detected at very early stages in the workplace and the desire to hold one's job can be a highly motivating factor in treatment. More than 100 Institute-trained occupational program consultants are presently employed at the State level. More than 300 new occupational programs have now been established by these consultants without Federal funding assistance and currently serve a work force of nearly 2,750,000 people.

We anticipate that these efforts will be carried forward by the States should the block grant proposal be accepted.

Significant partnerships also have been developed with the Civil Service Commission and the Department of Defense to foster congressionally mandated occupational programs for Federal employees and servicemen with alcohol-related problems.

Programs are being supported for reaching Indians, and communities composed of poverty and minority group populations which have a high incidence of alcoholism and which traditionally have been lacking in services. Included are projects serving women, youth, blacks, Spanish-speaking Americans, migrant workers, public inebriates, and criminal justice populations.

In regard to services for Indians the budget provides for the transfer of 151 Indian alcoholism treatment programs and 12 million dollars to the Indian Health Service, with NIAAA providing staff assistance to assure the long-range success of the projects.

NIAAA supports a programs of research on the biological, psychological, and social aspects of alcohol use and abuse. One outstanding and continuing Institute-supported study—in which baboons are used—has demonstrated that cirrhosis and other liver damage in alcoholics results directly from the toxic effects of alcohol, and not from a concurrent poor diet or impurities that may be present in alcoholic beverages.

Because of the extent of alcohol abuse and a disquieting rise in consumption among young people, the 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, YMCA, and others. Early in 1975, an estimated 500 national, voluntary, citizens, and youth organizations were identified that before had not directly involved themselves in alcohol-related problems.

In response to other serious drug problems in the Nation, the National Institute on Drug Abuse is working vigorously to strengthen a nationwide network of treatment centers for drug abusers and to prevent further increases in the number of people who abuse drugs.

Concern about an apparent rise in the use of heroin and the persistent, worrisome abuse of other drugs throughout the country resulted in recommendations in the recent Domestic Council White Paper on Drug Abuse that the drug abuse treatment network be expanded to meet growing demands.

In response to these recommendations, the 1977 budget proposes that NIDA-supported treatment capacity be increased by 7,000, bringing the total to 102,000 persons who could be treated at any one time. These community-based treatment programs will continue to receive direct Federal support at a minimum of 60 percent of total costs, and it is not proposed that they be consolidated into a State bloc grant program. Utilization rates at these treatment facilities remain at nearly 100 percent.

Another initiative in response to the White Paper will be a new treatment demonstration effort focusing on amphetamines and barbiturates, stimulant and sedative drugs, which are being increasingly abused.

In current drug abuse treatment programs, research plays a vital role. In the efforts to control narcotic addiction, the synthetic narcotic methadone is widely used as a stabilizing agent. But, in clinical trials, scientists are also testing the efficacy of a long-acting variant of methadone, and of the narcotic antagonists which actually block the effects of opiates.

The proposed budget includes increases for clinical evaluations of the effectiveness and differential outcome of current drug abuse treatment approaches, agents and procedures, to understand what works best under which conditions. It also provides for the initiation of a long-term study of marihuana smokers in the United States to determine the effects of chronic use of this drug.

Along with treatment and research, NIDA is spurring increasing activity in the field of drug abuse prevention, particularly among young people, by developing prevention models and supplying consultation and technical assistance to community-based programs and Single State Agencies.

Let me now turn to the National Institute of Mental Health which, for now close to 30 years, has been a stimulus for—and participant in—many of the dramatic changes in the national mental health scene.

In the mid-1950's, the number of patients confined to State and county mental hospitals was at an alltime high of 559,000. At that point, a downward trend began with the advent of psychocative drugs. Twenty years later, the number of hospitalized patients had dropped 50 percent.

By themselves new drugs—however beneficial their effects—could hardly be expected to be a cure-all. Disturbed people who stayed in or returned to their communities needed continued care and encouragement. To provide this care, the community mental health centers programs was launched in the mid-1960's.

At the end of the last fiscal year, 603 centers had been awarded Federal grants. When fully operational, they will make services available to almost 87 million people. More than half the centers serve poverty areas, and their services have been extended to include services for the elderly and for children, and for alcohol and drug abusers, among others. These programs are also proposed for inclusion in the block grant program.

Progress in treatment and services, as in efforts to prevent the onset of mental illness, depend on continued, extensive research of high caliber. Some recent NIMH research program highlights include a major collaborative program in which investigators at five facilities around the country are studying the nature and origins of depressive illness, and a three-hospital collaborative study on the effects of drugs and behavior modification on emaciated patients suffering from the self-starving emotional disorder, anorexia nervosa.

Clinical investigation of new areas of psychotherapy continues, in the effort to assess innovative approaches, among them the use of biofeedback in the treatment of such disorders as asthma, insomnia, and hypertension.

In what has been described as a major breakthrough, the NIMH intramural research program has developed a method of indirectly measuring glucose consumption in localized areas of the brain—a technique offering extraordinary advantages over existing methods of studying brain function.

These, of necessity, are only a few examples of the Institute's mission to probe the mysteries of mental illness and determine the bases of mental health—a mission it will continue to fulfill with unflagging enthusiasm in the new fiscal year.

In conclusion, Mr. Chairman, this appropriation request for Alcohol, Drug Abuse, and Mental Health in 1977 is $623,331,000, a comparable reduction of $188,671,000 below the total 1976 appropriation. The overall decrease results from a decrease of $66,558,000 related to the phase out of training programs, $54,364,000 related to the decline in Federal support of community service projects, $53,500,000 associated with the 1976 supplemental appropriation for CMHC's which is being requested for rescission, a reduction of $9,900,000 in alcohol formula grants, a $14,412,000 reduction in the level of research funds, a decrease of $286,000 in program management funds, and a reduction of $10,600,000 in Buildings and Facilities. In regard to the last item mentioned, it should be noted that the administration is proposing to appropriate $75 million in construction and modernization funds for St. Elizabeths Hospital in a separate legislative proposal. These decreases are offset by an increase of $20,949,000 to expand the drug abuse community programs.

Mr. ISBISTER. I would like to take a minute to highlight a couple of items within the statement.

As you have indicated, the members of the committee have available to them the statement and have read it. It highlights a number of accomplishments that we have made over the last year and summarizes the budget in some of its most salient features for you. With that, I will conclude, and we will respond to questions, Mr. Chairman.

BUDGET REDUCTIONS

Mr. FLOOD. All right. After reading your statement, I cannot help but have the feeling of sort of a split personality.

On the one hand, in that statement you made an excellent presentation in identifying the problems of alcoholism, drug abuse, and mental health. And then out of nowhere, suddenly, on the last page of the statement—all of a sudden, bang. On the last page of the statement you are going to solve all these terrible problems that you presented so ably and well in the statement, by cutting $188,671,000 from the budget. What are you, Houdini? How do you do that?

Mr. ISBISTER. Well, I think that it will require some magic, Mr. Chairman.

Mr. FLOOD. That is an understatement.

Mr. ISBISTER. We have before the committee a proposed budget of $623 million, which is still a very substantial amount of money for these programs. With those funds we will continue our programs of support for research, including the initiation of some new research projects during fiscal year 1977.

In the area of training, the budget again proposes the phaseout of our training and manpower development programs, with the exception of the postdoctoral fellowship.

As to our community programs, the budget proposes that the alcohol and mental health service delivery programs, both the project and formula grants, be included in the administration's health block grant proposal. However, we have included within this budget funds for the continuation costs of existing projects which have been supported in previous years.

Mr. FLOOD. Well, all right. Suppose you tell us what will be the program impact as a result of this proposed cut of $40,861,000 for the alcoholism programs. In other words, what specific areas get cut here, and what reduction in service is going to result?

Mr. ISBISTER. The $40,861,000 reduction for alcoholism, Mr. Chairman, would involve a $1½ million reduction in research. It would involve a $5½ million reduction in training programs; a $23 million reduction in the overall level of support of project grants for service delivery projects throughout the country; and a reduction of $9.9 million for formula grants to the States.

ALCOHOLISM RESEARCH

Mr. FLOOD. Suppose you describe briefly for us—briefly tell the committee what kinds of alcoholism research are you supporting, and identify some of the most promising areas in this research.

Mr. ISBISTER. I would like to respond to that briefly, and then ask Dr. Noble to elaborate.

Mr. Chairman, we have been supporting research on the biology of alcoholism and on some of the behavioral dimensions. Our research advisory panels for alcoholism have recommended that we keep roughly an even balance between biological and psychosocial research.

We have supported research on the effect of alcohol on specific body organs and functions. Some of the most important recent research findings have dealt with the effect of the use of ethanol on the liver and its functioning. For example, Dr. Charles Lieber, has done some very important research on the effect of alcohol consumption on the liver.

Mr. FLOOD. What are you trying to prove?

Mr. ISBISTER. We are trying to understand the short- and long-term effects of alcohol on the liver as an organ.

Mr. FLOOD. That is pretty generally accepted. The man in the street, for years and years, has identified some relationship between the consumption of alcohol and an effect on the liver. That is common talk. What is so special about it?

Dr. NOBLE. There have been some notions that if you have good nutrition, your liver will not be damaged if you take alcohol. The

studies we have supported have shown that despite an adequate nutrition——

Mr. FLOOD. You mean a good diet?

Dr. NOBLE. Yes—your liver can still be assaulted by alcohol. Now the studies that Mr. Isbister is referring to are designed first of all to create a model, an animal model, to study alcohol's effect on the liver. And here we have recently discovered that the baboon can go through the whole series of reactions in terms of its liver to create cirrhosis. You may say that is nothing new, because we know cirrhosis occurs in man. Our contention is, now that we have this model, Mr. Chairman, we can design drugs that could block the development of cirrhosis.

Mr. FLOOD. All right.

### UNIFORM ALCOHOLISM INTOXICATION AND TREATMENT

Last year we talked about the implementation in the various States of the Uniform Alcoholism Intoxication and Treatment Act. You told us last year 21 States had adopted the act, at that time. How many more States have adopted the act?

Mr. ISBISTER. Twenty-five States have now adopted the act, Mr. Chairman.

Mr. FLOOD. So we picked up four.

Mr. ISBISTER. Furthermore, an additional 11 States have adopted some but not all provision of the act

Mr. FLOOD. Well, what do you plan to do in this area in 1977?

Mr. ISBISTER. Well, we have the formula grants, as I mentioned earlier. They go to the States and can be used to assist in the development of alcoholism programs. The budget before you, Mr. Chairman, would propose that we make no new incentive grants to the States for implementation of the Uniform Act.

You must remember, of course, that under the block grant proposal, the States are free to provide funds for these activities if they wish. We have in the past awarded special grants to 16 States which have enacted the Uniform Act. The States can use the special grants to organize and implement various programs which are necessary as a result of the Uniform Act, particularly decriminalization of public inebriation.

### INSURANCE COMPANY COVERAGE

Mr. FLOOD. Last year you talked about a model—I think the phrase was yours—a model insurance benefit package for alcoholism. You told us that there were seven insurance companies that had adopted this model. Well, have you made any additional progress in this area at all?

Mr. ISBISTER. Yes, we have, sir.

Mr. FLOOD. If the insurance companies will extend this coverage, that certainly will be a major step forward in this area.

Mr. ISBISTER. As we discussed last year, we are concerned about that in all three of our program areas. The Alcoholism Institute has done a particularly good job in developing the model benefit package that you referred to, and together with the other two Institutes has continued to work with the insurance industry to promote the inclusion of benefits for alcoholism, drug abuse, and mental health in health insurance programs.

Now, I would like Dr. Noble to elaborate on specifically the progress this last year in alcoholism.

Dr. NOBLE. Maryland has just accepted the Blue Cross package. Also, California has had a modified system for its own State employees. Chicago has its own Blue Cross program going. So I think the word is spreading among the third party payment insurance people to pick up this kind of model package.

ALCOHOLISM TREATMENT EFFECTIVENESS

Mr. FLOOD. Now, also in your opening statement we have today said that a study of clients treated in a center, funded by your Institute, indicated that 70 percent—I will quote your phrase—"showed a measure of success" eighteen months after intake. What do you mean by that statement?

Mr. ISBISTER. The measures that were used in that study have to do first with the amount of alcohol that is being consumed by the clients, whether the level has decreased, whether the clients have abstained from the use of alcohol. They have to do with their employment characteristics, the number of days that they are currently employed as opposed to the number of days that they were employed before they entered treatment. They have to do with the income that they have earned after receiving treatment. They also have to do with their own self-perception.

Mr. FLOOD. With their what?

Mr. ISBISTER. With what the clients think of themselves as people, whether their self-esteem and self-perception have improved. Those are the measures which were involved.

OCCUPATIONAL ALCOHOLISM PROGRAMS

Mr. FLOOD. You also said that 300 new occupational alcoholism programs have been established without any Federal funding. That is a pretty impressive statement. Who paid for those projects, and how many more do you expect to establish during fiscal year 1977?

Mr. ISBISTER. Through our occupational alcoholism program we have given grants to the States to provide for occupational alcoholism consultants at the State level. And we have worked both with industry and with labor. We have a project with the National Council on Alcoholism, cochaired by James Roche of General Motors and George Meany of the AFL–CIO, which has been very effective in bringing the top leadership of the country, both from industry and labor, to develop and promote those programs.

Now, in terms of who pays for them, they will be paid in most instances by the industries themselves. Often the occupational alcoholism programs are negotiated as part of the labor-management agreement. I do not know what our prediction is for the number of new programs this year. I will have to ask Dr. Noble.

Dr. NOBLE. 300.

Mr. FLOOD. You say you have 300. I don't mean for you to be exact—an educated guess.

Mr. ISBISTER. We would hope to have an additional 300.

Mr. FLOOD. All right.

Now, you had a pretty sharp reduction here in the alcohol training program. What does that mean? Does that mean we have reached the point where they have a sufficient number of people now working in this field? Is that what it means?

Mr. ISBISTER. No. The proposals on training, Mr. Chairman, are not based on any conclusion that we have a sufficient number of trainees, or trained manpower.

Mr. FLOOD. A pretty sharp reduction.

Mr. ISBISTER. It has to do with the proposal that the Federal Government should reduce its efforts with respect to training. Many of the alcoholism training programs, like the drug abuse programs, were designed for short-term training of individuals who could serve in various service delivery settings. Some were designed to train community leaders. In a sense, a significant part of the short-term training was a catchup program, designed to train a number of individuals on a one-time basis.

Mr. FLOOD. Now, you touched on it, but I want to ask it in a different way: Are the labor unions and industry training people to work in this field? And if they are, how many of them?

Mr. ISBISTER. The answer is that there is some training which goes on in industrial settings, supported by industry.

Mr. FLOOD. What about labor—labor and industry, are they training people?

Dr. NOBLE. The airline pilots are training their own people in terms of recognition of alcohol problems. That is on a voluntary basis, with no funds from us. So there is some training going on.

Mr. FLOOD. How many?

Mr. ISBISTER. We don't have an exact estimate of that, sir.

Mr. FLOOD. There is not much of a program, where labor and industry as such are training people for this kind of thing, is there?

Dr. NOBLE. Not a big one.

Mr. MICHEL. If anything, it is all industry and nothing from labor, isn't that the truth?

Mr. ISBISTER. The AFL–CIO, the UAW, and some other unions have given a great deal of attention to the problem of alcoholism. However, I just don't know what they have done to train manpower to provide alcoholism services.

Mr. FLOOD. Well, along the same lines, have you conducted any studies about manpower needs in this whole field of alcoholism?

Dr. NOBLE. We are beginning—we have not done it, but we are going to initiate it this year.

Mr. FLOOD. Why not?

Dr. NOBLE. We have observed a demand for manpower in reviewing the State plans for formula funds and also by the number of applications for alcoholism training programs, but we have no hard data that tells us the total needs for alcoholism manpower in the country. I agree that it is important to get better data and we are going to be initiating some contracts this year to get an estimate of manpower needs.

Mr. FLOOD. What kind of followup do you do now to determine if the manpower trained are actually working in the field of alcoholism? And more importantly, are they working in these federally funded community alcoholism projects that we set up? You trained them, there they are. Where are they working? Are they working in projects we are putting up the money for?

Dr. NOBLE. About 80 to 90 percent of the people we train do stay in the field of alcoholism.

Mr. FLOOD. In what kind of projects?

Dr. NOBLE. Alcohol-related—prevention, treatment, and research.

Mr. FLOOD. Do they work in the ones we finance?

Dr. NOBLE. Yes, many of them do.

Mr. FLOOD. For the record, suppose you pick out several of those, will you—where, what, when?

Mr. ISBISTER. We would be pleased to provide that for the record, sir.

Mr. FLOOD. All right.

[The information follows:]

EMPLOYMENT OF NIAAA CLINICAL TRAINEES

The alcoholism training program is conducted with a view toward the diverse needs for alcoholism training in the country. The staffing requirements of NIAAA supported programs constitute only a small fraction of the overall need for specially trained manpower in the alcoholism field. We have no firm data as to the employment of persons trained by NIAAA. The Institute is in the process of negotiating a contract which will establish a comprehensive manpower information system, designed to provide a broad assessment of the quantities and types of alcoholism manpower needed, and also to provide a followup of individuals trained with NIAAA dollars. However, there are numerous instances of former NIAAA trainees whose current status of employment in the alcoholism field is known to us, and many of these are currently employed by programs receiving funding support by the NIAAA. The information below provides a few examples of the many NIAAA training programs whose graduates are now working in NIAAA supported programs:

1. NIAAA training program: Eagleville Training Program, Eagleville, Pa.
Current employer of former trainees—NIAAA supported programs:
Rubicon alcohol program, Richmond, Va.
Greater Lowell Council on Alcoholism, Lowell, Mass.
COMCA Youth Services Bureau, Abington, Pa.
Jackson County Alcoholism Treatment Center, Medford, Oreg.
Dartmouth-Hitchcock Mental Health Center, Hanover, N.H.
Panhandle Alcoholism Council Inc., Panama City, Fla.

2. NIAAA training program: John Hopkins School of Public Health, Baltimore, Md.
Current employer of former trainees—NIAAA supported programs:
Indian Chemical Dependency Coalition, Duluth, Minn.
Baltimore City Health Department, Alcoholism Counselor Training Program, Baltimore, Md.
Airline Pilots Association, Alcoholism Studies Program, Denver, Colo.

3. NIAAA training program: Rutgers University, New Brunswick, N.J.
Current employer of former trainees—NIAAA supported programs:
Alcoholism rehabilitation program, Paterson, N.J.
Community center for alcoholism, Watertown, N.Y.
United Progress, Inc., Alcohol Program, Trenton, N.J.

4. NIAAA training program: Southern University, Baton Rouge, La.
Current employer of former trainees—NIAAA supported programs:
Lafouche Parish Alcoholism and Family Counseling Program, Thibodaux, La.
Jefferson Davis Community Action Alcoholic Counseling & Rehabilitation Program, Jennings, La.

THIRD PARTY REIMBURSEMENTS

Mr. FLOOD. Last year you told us these alcohol treatment centers collect about 11 percent of their operating budget from third party reimbursements. Have you been able to increase the level of those reimbursements?

Mr. ISBISTER. Yes, sir.

Mr. FLOOD. To what level have you done it?

Mr. ISBISTER. For the period January through June 1975, alcoholism treatment centers received 14.6 percent of their income from the third-party reimbursements. That represents some progress, Mr. Chairman. I should point out that these figures relate only to those projects receiving staffing grants. The project grants to target populations have different rates. Some projects, such as those targeted toward public inebriates and Indians, receive very little in third-party reimbursements.

FEDERAL PROGRAMS SUPPORTING ALCOHOL ACTIVITIES

Mr. FLOOD. Now, about this reduction business, again. Does the reduction of the $40 million, that is reflected in this budget for the alcoholism projects, does that include the Indian alcoholism activities, which have been transferred over to the Indian Health Services?

Dr. NOBLE. No, it does not.

Mr. FLOOD. We understand, or we have information that $12 million will be transferred to the Interior Subcommittee on this. Is that correct?

Mr. ISBISTER. We are proposing that the alcoholism service delivery projects for Indians be transferred to the Indian Health Service, and therefore, that budget request would fall under the jurisdiction of the other subcommittee. It is my understanding that their 1977 budget includes $12 million for these projects.

Mr. FLOOD. For the record, would you insert a table in the record describing the HEW, as well as all other Federal programs, which provide support for alcohol research, alcohol treatment, alcohol training. In that table we want the name of the program and the dollar amounts for 1975, 1976 and 1977, fiscal years.

Mr. ISBISTER. We have that information, sir, and we will submit it for the record.

Mr. FLOOD. All right.

[The information follows:]

TOTAL FEDERAL FUNDS FOR ALCOHOLISM (OBLIGATIONS)

(DOLLARS IN THOUSANDS)

| | 1975 Actual | 1976 Estimate | T.Q. Estimate | 1977 Estimate |
|---|---|---|---|---|
| Treatment and Rehabilitation | | | | |
| DHEW: | | | | |
| ADAMHA 1/ | $125,808 | $100,973 | $12,098 | $70,943 |
| SRS | 35,000 | 41,000 | 10,000 | 43,000 |
| Human Development | 30,600 | 29,920 | 7,480 | 30,240 |
| HSA | --- | --- | --- | 12,000 |
| Asst. Sec. for Health | --- | --- | --- | --- |
| Subtotal DHEW | 191,408 | 171,893 | 29,578 | 156,183 |
| Dept. of Defense | 10,508 | 12,679 | 3,226 | 13,575 |
| Veterans Administration | 53,427 | 56,181 | 14,471 | 57,896 |
| Dept. of Justice | 334 | 340 | 85 | 340 |
| Other | 2,793 | 3,452 | 743 | 3,920 |
| Total Treatment and Rehab. | 258,470 | 244,545 | 48,103 | 231,914 |
| Prevention and Education | | | | |
| DHEW: | | | | |
| ADAMHA | 23,059 | 22,305 | 300 | 17,392 |
| Dept. of Defense | 2,093 | 2,596 | 652 | 2,729 |
| Veterans Administration | 345 | 345 | 87 | 345 |
| Dept. of Transportation | 470 | 538 | 86 | 819 |
| Other | 1,081 | 987 | 231 | 1,012 |
| Total Prevention and Educ. | 27,048 | 26,771 | 1,356 | 22,297 |
| Research | | | | |
| DHEW: | | | | |
| ADAMHA | 11,099 | 11,504 | 3,600 | 10,000 |
| NIH | 3,000 | 3,200 | 800 | 3,200 |
| Subtotal DHEW | 14,099 | 14,704 | 4,400 | 13,200 |
| Dept. of Defense | 111 | 110 | 27 | 65 |
| Dept. of Transportation | 9,429 | 9,152 | 1,090 | 3,317 |
| DOL | 101 | --- | --- | --- |
| Total Research | 23,740 | 23,966 | 5,517 | 16,582 |
| Training | | | | |
| DHEW: | | | | |
| ADAMHA | 11,420 | 7,458 | 2,300 | 2,000 |
| Other | 766 | 931 | 212 | 952 |
| Total Training | 12,186 | 8,389 | 2,512 | 2,952 |
| Planning, Evaluation and Coord. | | | | |
| DHEW: | | | | |
| ADAMHA | 10,531 | 8,053 | 1,400 | 7,011 |
| Other | 1,278 | 1,490 | 364 | 1,498 |
| Total Planning, Eval. & Coord. | 11,809 | 9,543 | 1,764 | 8,509 |
| Total Alcoholism Funding | 333,253 | 312,214 | 59,252 | 282,254 |

1/ Includes estimated 8.4% CMHC staffing grant obligations related to delivery of alcohol services.

Mr. FLOOD. All right.

COORDINATION OF FEDERAL ALCOHOL PROGRAMS

Now, why is it necessary for both the National Highway Traffic Safety Administration and the National Institute for Alcohol Abuse and Alcoholism to undertake research on the effects of alcohol on driving behavior? Why?

Mr. ISBISTER. Well, I would be concerned, Mr. Chairman, if both were undertaking research of that sort without each being in touch with the other. At the staff level there is a good working relationship between the National Highway Traffic Safety Administration and the NIAAA.

I would ask Dr. Noble to comment in terms of the specific division of labor.

Dr. NOBLE. Mr. Chairman, we actually do very little in this respect in terms of the traffic problems related to alcohol.

Mr. FLOOD. What do you mean by "we"?

Dr. NOBLE. The Institute. We do collaborative work with NHTSA through our clearinghouse, in preparing information for them that they distribute. And we also work with them in terms of their identification of drinking driver problems, and we treat these people. So it is a collaborative venture.

Mr. FLOOD. If that is so—you must have a procedure to do this. You just don't do it off the cuff. What procedure do you actually employ to insure each organization is kept fully aware of the research needs, the plans, and the decisions of the other. What is the procedure?

Mr. ISBISTER. We have a formal agreement, sir, which was signed by the Secretary of HEW and the Secretary of Transportation.

Mr. FLOOD. If that is not a lengthy document, we would like the gist of the agreement for the record.

Mr. ISBISTER. Yes, sir, we will supply it for the record.

Mr. FLOOD. Is it too long to insert the entire document?

Mr. ISBISTER. No, sir, it is not.

Mr. FLOOD. All right. Suppose you do that, then.

[The information follows:]

MEMORANDUM OF UNDERSTANDING BETWEEN ALCOHOLISM PROGRAM AND THE DEPARTMENT OF TRANSPORTATION

At the time the following memorandum of understanding was prepared, the alcoholism program was a division under the National Institute of Mental Health. A later reorganization resulted in the establishment of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) within the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). NIMH is now one of the other two Institutes with ADAMHA.

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MEMORANDUM OF UNDERSTANDING
BETWEEN
THE NATIONAL INSTITUTE OF MENTAL HEALTH
DIVISION OF ALCOHOL ABUSE AND ALCOHOLISM
AND
THE NATIONAL HIGHWAY SAFETY BUREAU

BACKGROUND

The National Highway Safety Bureau (NHSB) has identified alcohol in relation to highway safety as a priority area of action within the Bureau's overall program to support State highway safety efforts. This priority flows naturally from the extensive highway research literature which identifies alcohol as a factor in at least 50 percent of all fatal highway accidents. As a result of this designation a new, intensive action program has been developed and is currently being implemented throughout the country. This program when fully operational will include not only aid to State safety programs on a fifty-fifty basis as in the past but in addition will involve a major national public education program, an extended research and development program, and a major community action program involving the initiation of "Alcohol Safety Action Programs" (ASAP) in each of the fifty states.

In keeping with the Secretary of Transportation's 1968 Report to Congress on Alcohol and Highway Safety this program identifies the problem drinker who drives as the major contributor to highway deaths related to alcohol. While the program is focused on the problem drinker, it is also expected to deter excessive drinking and driving by social drinkers. In focusing on the problem drinker the program stressess the need to provide methods by which convicted drinking drivers may be referred by courts for treatment and rehabilitation rather than sentenced to the standard penalties presently in use which appear to be ineffective in deterring their drinking and driving.

Concurrent with the development of this new NHSB effort the National Institute of Mental Health (NIMH) has been increasing their activities in the area of alcohol abuse and alcoholism. The first step in this direction was the reorganization of the Alcoholism Center into a new Division of Alcohol Abuse and Alcoholism. With this reorganization has come an increased funding commitment and a broadened program. In addition, the Hughes Bill currently being considered by the Congress would further increase the budget and activities in alcoholism. The NIMH program includes both support for improved treatment of alcoholics and problem drinkers and public health programs designed to reduce the incidence of alcoholism. As part of the former, support for community and State alcohol treatment activities will be provided. As part of the latter, there will be a national public education program in alcohol abuse.

The NHSB and NIMH programs embody several areas of mutual concern where interagency cooperation and support will be essential. The NHSB program to identify problem drinkers who drive and bring them into treatment is essentially a case finding technique which should in many communities increase the number of problem drinkers being brought into treatment. Unless these communities can find sources of support to increase their capability, they will have difficulty handling this new case load. Thus NIMH must work closely with the Bureau to help the communities involved in ASAP programs to find funding support for the allied alcoholism treatment activities. In the area of public education the goals of both agencies are similar in many respects. The NIMH hopes to produce an understanding of the nature of problem drinking and of the early symptoms of this disease in order to help individuals avoid alcoholism and in order to get individuals into treatment at an earlier point in the progress of the disease.

The NHSB is interested in the public having understanding of the same information in order that more problem drinking drivers may be brought into treatment prior to being involved in accidents and so that the public itself will better understand the nature and dangers of excessive drinking and thereby avoid such drinking and driving.

Because of the many areas of commonality which produce a need for internal support and cooperation in alcohol programs, an interagency agreement is needed to ensure that provision is made for technical assistance, for coordination of policy and for transfers of funds between the two agencies in areas of mutual interest. It is intended that this general agreement will provide a basis for more specific and detailed agreements as needed during the prosecution of these alcohol programs. Specific assignments of personnel, transfer of funds, joint policy statements will be made under this general agreement as needed. Each agency shall appoint a staff member to be responsible for liaison with the other agency under the terms of this agreement.

Because of the nature of the programs described above, it is expected that liaison and cooperation are needed in the ten areas described below:

1. ASAP Proposal Evaluation: From October of 1970 to March 1972 the National Highway Safety Bureau expects to be evaluating approximately 150 applications and approximately 40 to 50 proposals for ASAP community action programs. Each of these programs will have a section on procedures for the courts to refer problem drinkers for treatment. The NHSB requires the assistance of the National Institute of Mental Health in evaluating these applications and proposals to ensure that the procedures proposed are appropriate and that the treatment facilities in the sites will be adequate to handle the increased load of patients being produced by the traffic safety program. As part of this agreement the NIMH agrees to provide a consultant to review the applications and proposals and assist in their evaluation by the National Highway Safety Bureau.

2. ASAP Site Surveys: The National Highway Safety Bureau requires the assistance of the National Institute of Mental Health in conducting site surveys and providing consulting assistance to communities which are undertaking ASAP programs. Each of these communities will have a need for treatment facilities adequate to handle the increased patient load being produced through the traffic court system. In order to ensure that these facilities are available, on-site surveys need to be conducted by qualified consultants of the NIMH Division of Alcohol Abuse and Alcoholism at each of the approximately 50 sites which will be funded during the next 18 months. These visits would result in a report to the NHSB regarding the treatment capabilities in the communities concerned and would also provide assistance to the local community in developing their treatment program in conjunction with ASAP acitvities. This assistance could take the form of (a) technical advice on treatment programs, (b) assistance in developing grant requests to the States or to the National Institute of Mental Health and (c) other activities as required by the local alcohol program groups in order to assure that the treatment facilities will be adequate to the needs of the ASAP programs. In some cases more than one site visit may be required. In addition, some of the consultant's time at his own place of business may be required to accomplish these activities. The NHSB will transfer to the NIMH funds not to exceed $50,000 in any fiscal year to support the activities of these consultants.

3. Consultants: The NHSB requires consulting services from specialists in the area of alcoholism, alcohol abuse and medical physiological and psychological problems relating to alcohol and drug abuse. To assist the NHSB in this area the NIMH will provide access to its consultants on a cost reimbursable basis. The NHSB expects to use no more than 10 such consultants for no more than a total of 60 days for all 10 consultants in any fiscal year. The NHSB will reimburse the NIMH for the time and travel of such consultants on the basis of specific requests for assistance initiated by the NHSB.

4. Roles and Missions: While the roles and missions of the two agencies are generally clear it is expected that further clarification in specific detailed areas will be desirable. In general the two agencies will operate within the philosophical framework of the 1968 Moynihan Report. In addition, specific agreements will be made regarding those expenses which will be funded under ASAP projects and those treatment expenses which will be borne by NIMH or other health agencies or programs supported in part by NIMH. Specific examples of the types of detailed agreements required will be those regarding nature of treatment and education activities which will be paid for out of ASAP projects as compared to NIMH projects. In general the NHSB has taken the position that it will not support treatment or rehabilitation activities for problem drinkers but will support certain educational and record keeping activities in connection with problem drinkers who drive. Thus, the NHSB will support driver improvement education programs directed specifically at problem drinking and driving even where these may involve group discussions and other activities similar but not identical to "group therapy" treatment procedures. The details of the interface between what can legitimately be supported by transportation safety programs and those activities which should be supported by health agencies will be further specified in a subagreement to this general agreement.

5. Foreign Programs: Both the NHSB and NIMH have considerable interest in foreign alcohol safety and alcoholism programs. The differing foreign cultures and the difference in the willingness of foreign governments to regulate both the area of drinking and the area of driving produce a number of field experiments which can be very useful to the United States in developing and testing concepts for both traffic safety and alcoholism programs. The NIMH currently has a number of research activities underway in foreign countries. Similarly the NHSB has been active in the OECD and NATO traffic safety activities. It is highly desirable that both agencies in their foreign programs are aware of the needs for information of the other agency and where possible make provision for gathering data of interest to that agency. For example, studies of foreign drinking habits can frequently be combined with studies of highway accidents and driving behavior in such a way as to yield insight into drinking-driving problems. Where opportunities for this type of research arise cooperative programs should be instituted. To support such cooperative activities appropriate transfers of funds from one agency to the other will be made on the basis of the specific needs of each project.

6. Public Education: Both the NHSB and NIMH plan to initiate major public education and information programs. The NIMH has already advertised for bidders and will shortly release an RFP for its own program requirements. The NHSB has also been developing an RFP for advertising agency services to develop a public education campaign. Considerable time and monetary saving may be possible by joining the two efforts. Therefore, the NHSB agrees to join the NIMH in the solicitation through an RFP of the services of an advertising agency to develop a national public education program in drinking and driving. For this purpose a transfer of funds will be made in the amount of $100,000 with further funding to be transferred if required once the final contract is signed. To ensure effective coordinated management of this dual program, a specific management agreement will be drawn up between the NHSB and the NIMH for the public education program. This agreement will define the methods of technical and financial management and the types of support which will be provided by each agency. This agreement will specifically provide for the distribution of public information materials cooperatively through the channels of each agency.

7. Research: Because of the NHSB's special interest in problem drinking as related to driving many research proposals which are considered for funding lie on the borderline of the responsibilities of NIMH and NHSB. It is highly desirable, therefore, that close contact coordination of research funding activities occur between the two Bureaus. In some cases programs will be appropriate for support by NIMH, in others by NHSB and in a few cases joint support may be appropriate. As a part of this agreement each agency agrees to provide consulting services on the review of any studies submitted to the other agency

which appear to be of mutual interest. In addition joint research projects will be undertaken where clearly appropriate. In such a case a transfer of funds between agencies will be made as required by the specific case.

8. Private Sector Liaison: Both the NHSB and the NIMH have considerable interest in, and responsibility to, medical treatment groups related to alcoholism and alcohol abuse. As a part of this agreement, both agencies agree to work jointly in efforts to coordinate their activities with private medical and treatment agencies. Specifically, the NHSB agrees to join with the NIMH in participating in an ad hoc group formed under the chairmanship of the AMA to coordinate information and activities on alcoholism. Each agency agrees to support the other agency's request for meetings of this group and for the support of the organizations which make up the ad hoc group.

9. Liaison with Government Agencies: NIMH has already undertaken leadership of alcoholism programs within the U.S. government agencies. The NHSB has an interest and responsibility in traffic safety programs within government. The two agencies agree to cooperate in the area of drinking-driving safety programs for government agencies and agree to exercise leadership in this area by supporting government agency drinking-driving programs, and by providing information on alcohol and drug abuse in relation to driving for the use of the various government agencies.

10. Information Exchange: Both the NHSB and the NIMH are regularly producing research reports, brochures and other material of interest to both agencies. Each agency agrees, therefore, that they will make a provision in all of their information distribution activities to assure that the other agency is given copies of all materials produced relevant to that agency's concern.

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Mr. FLOOD. Now, Public Law 93–282 directed the Secretary of HEW to establish the Interagency Committee on Federal Activities for Alcohol Abuse. That is the title. Now, in view of all these many agencies involved in the alcohol-related activities of all kinds, and as you say we agree there is a need to coordinate these activities—why hasn't the Department established this committee directed by laws? Why?

Mr. ISBISTER. The committee has now been chartered, Mr. Chairman.

Mr. FLOOD. Chartered?

Mr. ISBISTER. Formally chartered.

Mr. FLOOD. What does that mean?

Mr. ISBISTER. The Federal Advisory Committee Act requires a formal chartering of public advisory committees through the Office of Management and Budget. The Secretary is now making his decisions with respect to the appointment of the public members of that committee. The principal reason for the delay—and I am responsible for that personally—is the fact that the Director of the National Institute on Alcoholism, Dr. Chafitz, resigned last summer. I delayed the implementation of that committee until Dr. Noble was on board, because the committee needed the leadership of the Director.

Dr. Noble is now on board. We are processing the appointments through the Office of the Secretary. And we would anticipate that the committee will be meeting for the first time in April.

Mr. FLOOD. How long have you been on board, Doctor?

Dr. NOBLE. Officially 2 weeks.

Mr. FLOOD. All right. Doctor, you know that our surveys and investigations staff of the committee is currently reviewing the alcohol programs of HEW, and the Department of Transportation as well. Although they have not completed the report yet, they have given us a list of questions all about the operation. We want you to answer those questions carefully and completely for the record.

Mr. ISBISTER. Yes, sir.

Mr. FLOOD. Take your time on that.

[The questions and answers follow:]

Questions for the Record Submitted by Mr. Flood

1. What, specifically, was accomplished by the Jaycees' Operation Threshold during the first three years of its grant?

During the first year of Operation Threshold, the National Jaycees undertook a massive information and training program for its own membership. The main objective during this first year was to increase the level of awareness about the responsible use and non-use of alcohol and to make certain that the National Jaycee membership had a clear understanding of the adverse effects of alcohol when used indiscriminately. A national seminar was conducted to train program directors in prevention and education for each of the States and territories.

During the first three years, the U.S. Jaycees began developing and distributing education and prevention materials including training manuals, resource directories, informational pamphlets directed at families and news letters providing the latest information to the JC membership and local communities.

A mini-grant program for State and local organizations was established to stimulate prevention activities. Approximately 812 mini-grant projects were established between 1972 and 1975. Throughout the course of the first three year grant period, approximately 1,060 prevention programs were established through the mini-grant mechanism across the U.S.

The National JCs, through its professional staff in Tulsa, Oklahoma, served as a resource to other national voluntary organizations and professional associations that had begun addressing themselves to the use, misuse and non-use of alcohol. Technical assistance to local and community programs was provided.

Regional seminars were held to assist local alcoholism program people in developing training for staff and effective mechanisms for evaluation of prevention programs.

The JCs have been able to persuade most of its 7,000 chapters with a membership of 325,000 young men, to establish educational and informational programs and through the national headquarters is providing the necessary materials for these programs to be maintained.

This demonstration project serves as a model to show how the Federal Government and a national voluntary organization could join together in a partnership that would increase the level of awareness about the use of alcohol and at the same time serve as a model for other organizations on how to begin addressing the ambivalence that surrounds the use of alcohol in our society.

The National JCs also developed ten project kits which could be disseminated at no cost to churches, small business employers, community health providing agencies and to the media.

2. How have the activities of the Jaycees resulted in a reduction in alcohol abuse and alcoholism?

A reduction of alcohol abuse can only be reliably measured over an extended period of time and, even then, it is difficult to attribute a reduction to any single factor. However, we do know that through the efforts of the JCs in collaboration with NIAAA, there is an increased awareness of the dangers associated with the misuse of alcohol. We are also able to observe that alcohol is more readily discussed in the open and has become a major concern of educators and health providers during the period of this grant. We also know that because of the JCs' leadership, a number of other voluntary organizations, which heretofore had not addressed themselves to this number one national drug problem, have begun education and

prevention programs. Among these organizations are the General Federation of Women's Clubs, the National Congress of Parents and Teachers (PTA), Boys' Clubs of America, the National YMCA, and the Education Commission of the States.

3. Was a cost-effectiveness analysis made of the Jaycees' Operation Threshold Grant before its renewal at the end of the first three-year grant?

Yes. Within the National Institute on Alcohol Abuse and Alcoholism, a thorough program and administrative review takes place on all grant applications prior to approval for payment. Included in this process is a cost effective analysis of grants before a renewal is recommended for approval. An analysis of the first three years of this grant provided the following: 1) $225,700 in mini-grants funded by the JCs actually generated $1,740,000 worth of prevention education activities. For every dollar expended under this grant, approximately $7 worth of program activity in prevention took place. A total of 1,325 JC chapters with no NIAAA funds generated approximately $700,000 worth of manhours in voluntary work in the field of alcohol abuse and alcoholism. Under the sponsorship of this grant, 2,200 key leaders at all levels of the JC's membership were trained in prevention and education techniques and in turn worked with local community education programs. Five major publications that have become extremely popular were designed and developed by the JCs under this grant and have been widely disseminated through the National Clearinghouse for Alcohol Information. In addition, ten program kits, which provide materials and techniques for prevention programs were developed. It is estimated that approximately 2,000 local, State and national organizations were reached by the JCs under this grant.

4. What was the justification for the most recent renewal of the Jaycees' grant?

It was the opinion of the technical review committee, NIAAA, that whereby the first three years of this grant had produced a major constituency for the alcoholism field that was made up of individuals and organizations that heretofore had not considered alcohol prevention to be an important national priority, that continued support was a highly significant and cost effective investment of Federal dollars. During the three years of this grant, 900 local and State projects had been undertaken. Thousands of non-grant activities had been mounted through local JC chapters. Because of the JC leadership, groups such as Fortune 500, B'nai B'rith, the Education Commission of the States, took on prevention of alcohol abuse and alcoholism as a major program responsibility. However, the JCs realized that there was still a number of target populations to be addressed -- these include women, youth, minorities and the elderly.

The review committee believed that the momentum, technical experience and skill which had been developed by the Jaycees over the initial three years of the project would prove invaluable in increasing the involvement of the public and private sector in community alcoholism prevention activities.

5. What changes can be made in the Operation Threshold Grant to make possible a more direct evaluation of the effects on a community in which the program operates, particularly the effects on alcoholism?

There is the need for long range longitudinal studies to determine the attitudinal and behavioral impact of the JCs' grant. By the time this current renewal is concluded, we will have important information as to how this grant has reduced the incidence of alcohol abuse and alcoholism. This is in addition to secondary evaluation data which indicates the degree of coverage provided by the Jaycees, and other performance results which I alluded to in previous questions.

Mr. Chairman, I believe the value of the Jaycees program can best be understood when one takes into account the pervasiveness of alcohol abuse in our country. The reluctance of many national organizations to address themselves to the al-

coholism problem only emphasizes the need to stimulate awareness which will bring about changes in public attitudes toward alcohol use.

We believe that the widespread prevention efforts of the Jaycees complement the Institute's basic mission of stimulating community awareness, changing attitudes, and developing community action toward alcoholism, and that this effort can lead to greater involvement by other organizations having a broad influence on the American public.

6. What fiscal and program audit surveillance does NIAAA exercise over project grants?

I view the responsibility of program and fiscal surveillance as basic to our role as effective program managers, and so Institute staff perform this function in accordance with their respective program and administrative assignments. To supplement our own day to day monitoring efforts, the Institute awarded a contract in the last fiscal year to provide close monitoring and furnish management and program assistance to our community project grantees.

In addition, the Institute relies on the audit agencies within the Office of the Secretary and the HEW regional offices to conduct fiscal audits of our programs. If the grantee or subgrantee is a State or local government, audits are to be made by the State or local government or at its direction to determine, at a minimum, the fiscal integrity of grant or subgrant financial transactions and reports, and the compliance with the terms and conditions of the grant or subgrant. Such audits are scheduled with reasonable frequency, usually annually, but not less than once every 2 years, considering the nature, size and complexity of the activity. Recipients other than State or local governments are encouraged to adhere to these standards.

7. How many States do not have adequate fiscal and program audits of alcohol and drug programs over which the State has responsibility?

As you know, a large part of the Institute's mission has been to work closely with the States in the development of State and local alcoholism programs. Our experience has been that in general the States have developed good fiscal and program management capability. Technical assistance is provided to the States both by NIAAA headquarters staff and the DHEW regional offices.

8. Would it not be feasible to devise and utilize uniform accounting procedures for each project, listing items that could properly be classified as administrative costs?

Due to the great diversity of the projects supported by the Institute, it would not be feasible to require identical accounting procedures for each grantee. The Institute has developed two model accounting systems, one for multiple direct service projects and one for limited direct service projects, which have been distributed to projects supported. Each project is encouraged to implement fiscal systems which embody the principles highlighted in the model system, however, each project must modify the model to meet its individual needs. The HEW has issued regulations, 45 CFR Part 74, which enunciated cost principles for HEW supported projects. These cost principles do identify for specific items of cost, the allowability and the types of costs to be charged as direct or indirect costs.

9. Would not the use of a uniform procedure facilitate comparisons between projects and enable both State and project level management to maintain better control of the cost effective operation of projects?

The use of a uniform procedure would, in theory, facilitate the comparison and control of projects. However, the uniqueness of the projects would make the application of a uniform procedure very difficult. The objective probably could be achieved by instituting basic principles that must be followed. Usually the difficulty in comparisons is not the differences in the fiscal system, but differences in the definition of the various programmatic activities.

10. How can research project officers ensure that research proposals under their review do not unnecessarily duplicate or overlap projects underway or under review elsewhere?

Peer review committee members are selected because they are currently active researchers highly knowledgeable of ongoing research in their field. As such they are keenly aware of any research being conducted either in the Institute or elsewhere, which touches on their respective areas of expertise. Also, our collaborative relationships with other Federal agencies significantly reduce the possibility of overlap.

New research applications under review in other Federal agencies are called to the attention of program staff by the following: (1) the applicant must indicate in his application any pending request to other Federal agencies for funds to support his research. (2) the Division of Research Grants in the National Institute of Health notifies staff of each program whenever two applications have been received from the same investigator, but assigned to two different programs and, subsequently, program staff exchange copies of proposals assigned to them and examine them for duplication.

11. A systematic and formal review by NIAAA, NIDA, and NHTSA of all DUI related research before it starts could enhance the quality of such research through coordination of research efforts and through more involvement of varied peer groups than now exists in each agency. Have such reviews been considered by any of the three agencies and, if so, what has prevented progress in this direction?

In establishing the Alcoholism Research Review Committee, it was intended to have only one group be responsible to evaluate the complete gamut of proposals requesting funds for alcoholism research without fractionating the field. The mission of the NIAAA research program is to study all aspects of alcoholism and alcohol abuse. This includes biomedical and behavioral investigations, studies of the etiology of alcoholism, the medical consequence of alcohol abuse and the effects of alcohol on behavior. Establishing a new interagency review committee seems impractical because (1) it would remove from the NIAAA an important part of its program responsibility and (2) the kinds of research proposals received by the NIAAA are of only peripheral interest to the NHSTA because they relate to alcohol and its effects rather than to highway safety specifically.

12. What procedures could be instituted to ensure that DUI related research findings are effectively and quickly disseminated to Federal, State, local, and private agencies that are likely to be able to benefit by having such information?

Procedures currently available should be strengthened since they appear to be sufficiently adequate for dissemination of new research findings. NIAAA grantees publish results of their basic research in scientific journals readily available to the scientific community at large and they make presentations at scientific meetings of professional societies as well as attend conferences and workshops.

The NIAAA is currently exploring the feasibility of publishing interim progress reports of work underway by its grantees. This new procedure could accelerate the dissemination of new findings.

13. Wouldn't coordination of research and peer group reviews of such research proposals be simplified if the NIAAA directed all such research, except when the features or design of the automobile are being questioned?

The objective of the NIAAA research grant program is the development of knowledge regarding the effects of alcohol use, abuse, and alcoholism, and so the range of studies that we support is very comprehensive. However, where the subject to be addressed is specifically in the area of highway traffic safety, it is understandable that the NHTSA would be in a better position to conduct or initiate such research. There are many research studies which touch on more than one subject area, not only where NIAAA is concerned, but in virtually any subject area. This Institute has collaborative relationships with other Federal agencies, so that both NIAAA and the other agencies can derive maximum benefit from research of mutual interest.

14. Why do both NIAAA and NHTSA undertake research on the effects of alcohol on the driver's visual responses (one NIAAA research grant is titled "Alcohol Intake, Search Activity, and Driver Performance")?

The NIAAA and NHTSA occasionally fund research in an area of interest to the other agency. With regard to the specific research on alcohol intake and visual search, the project is concerned with three aspects not central to the mission of NHTSA: (1) it will study alcoholic persons, (2) it will study the effects of psychoactive medication commonly used in the treatment of alcoholic patients, and (3) it will study the basic parameters of information processing capabilities of alcoholic persons. Use of the driver simulator is a matter of convenience to the investigator rather than an essential characteristic of the research objective: Nevertheless, the potential findings are of benefit both to the NIAAA and NHTSA and have implications for both programs.

15. What procedures can NHTSA and NIAAA implement to ensure that each is kept fully aware of the research needs, plans, and decisions of the other?

The research staff of NIAAA is in frequent contact with relevant staff of NHTSA as the need arises on problems of mutual interest. In the past, joint research efforts were undertaken on the preparation of a "state of the art" paper on sobering agents, and the subject effects of intoxication during ascending and descending blood alcohol effects. Close contact and collaboration between staff of NIAAA and NHTSA occur when a particular problem has both basic and applied aspects since these respectively, are the intents of NIAAA and NHTSA.

Also in your statement you said that research activities should be, must be, and are the highest priority of your entire agency—exclamation mark. Now, having said that, and convinced us about that, how do you explain the reduction of $12,908,000 for mental health research—question mark.

That is a good trick whether you do it or not.

How do you do that?

Mr. ISBISTER. The request for fiscal 1977, Mr. Chairman, was based on the President's budget for fiscal year 1976 and was to continue the program at the same level proposed in the President's budget. I would like to point out that within the budget, even with the reduction, we will be able to support about 110 regular new research projects during fiscal 1977.

Mr. FLOOD. In view of all that.

Mr. ISBISTER. Yes, sir.

Mr. FLOOD. Well, I hope you get your hope.

Now, briefly, again, with the right of going further for the record, tell us about the most promising work that you are now supporting what is it going to mean eventually to the patient?

Mr. ISBISTER. We have a number of new findings and discoveries that can be reported. I will ask Dr. Brown to respond at some length.

One of the most interesting and important discoveries has occurred in one of our own NIMH laboratories. One of our investigators has determined a new method of studying the brain function in terms of its consumption of glucose. This is a very important discovery in terms of what followup research can be done.

Mr. FLOOD. You say consumption of glucose?

Mr. ISBISTER. Yes, and how the brain handles glucose. I would ask Dr. Brown, the Director of the National Institute of Mental Health, to elaborate on this and one or two other significant research findings.

Dr. BROWN. I will pick just two or three examples. One important development is our ability to spot youngsters, age 3 or 4, who are going to have reading disability problems—to really spot them at 90 percent accuracy, and then successfully intervene so that they learn to read by the second grade. The implications are enormous for the parents, for preventing emotional problems, and other things that often follow from reading disability.

That is one example.

Another exciting one is that we are finally beginning to understand how nerves connect with one another. The connector mechanisms, or neurotransmitters, function by means of a complex process. Pursuing the chemical theory, we are making discoveries that will permit us to develop drugs and other chemicals that will help prevent or treat depression. As you know, for example, lithium has been very effective in treating certain manic-depressive diseases. We now know that as with cancer, if you mix the right drugs together, you can combat cancer. We are on the lead of putting together lithium and tricyclics, and it is very promising in treating depression of all sorts.

Third, we are finally getting at perhaps the key to schizophrenia. We are discovering how the brain works and finding ways that the actual chemical process leads to disordered thinking.

Finally, I would like to highlight what Mr. Isbister has just mentioned, because it may be one of the most important developments. This is like a chemical X-ray. The brain uses glucose as its gasoline. By using a little different form of glucose, you can get a chemical X-ray of how the neurons travel along the brain's pathways. Before, we had to cut slices from a brain and stain it to get a picture of the brain. Now you can actually track the processes as they take place. You put the special kind of glucose in the mixture and actually see what the pathways look like. It is about as important as the X-ray was for looking inside the body.

I could go on and on.

Mr. FLOOD. I'm sure of that, yes.

Dr. BROWN. But I think I will stop with those three.

COMMUNITY MENTAL HEALTH CENTERS

Mr. FLOOD. How much of the reduction of the $31,407,000 for the ongoing community mental health centers is attributable to the fact that these centers have reached their eighth and final year of support?

Mr. ISBISTER. It is partially attributable to that. We estimate there will be 76 which will have completed their 8 years of support during fiscal year 1977 and would therefore not receive funding in fiscal year 1977.

Mr. FLOOD. Is that a lot?

Mr. ISBISTER. It is 76 in relation to a total of some 600, which have been supported.

Mr. FLOOD. All right.

Mr. ISBISTER. In addition to that, though, part of the decrease is attributable to the fact that over the course of the statutory 8 years of support, the amount of the Federal grant, in terms of the percentage of total costs, goes down each year. The declining Federal share accounts for a substantial part of the reduction.

Mr. FLOOD. Is this $130,800,000 that you are asking for in this budget for the ongoing mental health centers sufficient to meet your continuing commitments under this law?

Mr. ISBISTER. The budget is designed to meet the continuing commitments under the old law, sir, the old Community Mental Health Centers Act, which was recently amended during the last year, and assumes that the Congress will rescind funds appropriated to implement Public Law 94–63.

Mr. FLOOD. All right. That being so, how much money, as of now, would we have to add to this 1977 budget for the community mental health centers in order to fund the continuation of the new centers that were initiated in 1976 as a result of this committee's action in rejecting the rescission request. How much?

Mr. ISBISTER. As I pointed out, our budget was based on the acceptance of the rescission. Our estimate of $41.6 million would be required in fiscal 1977 to continue projects started in fiscal 1976. This, of course, assumes enactment of the proposed block grant. Approximately $64.7 million would be necessary if the block grant program is not enacted.

Mr. FLOOD. $64.7 million, as a result of the rescission.

Mr. ISBISTER. Yes, sir.

Mr. FLOOD. Now, how many of the community mental health centers, which have reached their eighth and final year of support in 1976, are going to require financial distress assistance in fiscal 1977? How much money is going to be needed on that?

Mr. ISBISTER. Dr. Brown has previously estimated that, roughly, 10 percent of the centers that are graduating seem to be in great financial distress. An additional 10 or 20 percent seem to have financial problems. But to my surprise and our delight, it appears that 70 or 80 percent have been able to generate sufficient State and local support, and to increase their third-party reimbursements, in order to maintain their current level of services as the Federal grant reduces each year.

Mr. FLOOD. How much money is going to be needed? We are not going to hold you to a precise figure. Within reason.

Mr. ISBISTER. I don't have an estimate of that.

Mr. FLOOD. You should be able to do something on that for the record.

Do you want to pick one out of the air now within reason at all?

Mr. ISBISTER. I think it would be better to present that for the record.

Mr. FLOOD. All right.

[The information follows:]

COMMUNITY MENTAL HEALTH CENTERS REQUIRING FINANCIAL DISTRESS AWARDS IN FISCAL YEAR 1977

| | Number | Amount |
|---|---|---|
| Centers receiving 1st distress award in 1976, requiring 2d award in 1977 | 8 | $3,000,000 |
| Centers receiving initial distress award in 1977 | 11 | 4,000,000 |
| Total | 19 | 7,000,000 |

Now, Doctor, how many of your operational community mental health centers have established a really formal working relationship with other health service programs in their cachement area? I am speaking of the health maintenance organizations, our neighborhood health centers, and so forth.

Many of these health programs need mental health service. And we think every effort should be made now by you people to tie these things together, wherever they might be. We think that should be a mighty high priority in your operation.

Mr. ISBISTER. It is, sir. We are working as diligently as we can in that regard.

The principal link of the mental health centers to the general health care system has been through the general hospitals. But we have been working with those other components of HEW which administer the HMO programs, and the neighborhood health center and community health center programs, as well.

I do not have any data at my fingertips. Perhaps Dr. Brown, who has been working in these vineyards for a long time, might want to expand.

Dr. BROWN. Very briefly, of the 500 operational centers, 100 are based at a general hospital. Another 377 have a general hospital affiliation. Only about a one-fifth are one-agency organizations. Four-fifths have two or more agencies that they affiliate with. About one-quarter

are affiliated with the local neighborhood health center, HMO, or other health facility in the area. But everyone that has such a facility should have such affiliations. This is part of the thrust in the new law, and we will do everything to assure that that happens.

MENTAL HEALTH RESEARCH TRAINING

Mr. FLOOD. All right.

Now, again, the budget calls for a reduction of $9,624,000 for mental health research training.

What is going to be the impact of that kind of a cut? First of all, it is obviously going to mean fewer researchers in mental health research, isn't it?

It has to.

Mr. ISBISTER. Not necessarily, Mr. Chairman, because there are alternative sources of support. Students are able to obtain some loans for their training. I think that the effect might be some decrease.

As you know, the National Academy of Sciences is conducting a study of what the overall research training needs are in the country, in response to a request of the Congress.

Mr. FLOOD. We know about that.

Mr. ISBISTER. They are assessing the question of how the people need to be trained in the various academic disciplines to pursue careers in biomedical and behavioral research.

Our proposal in this budget is to phase out research training grant and predoctoral fellowship programs. The National Academy of Sciences is likely to recommend the continuation of Federal support for research training in particular areas. If the Academy so recommends, there are likely to be proposals forthcoming to support research training in specific areas of high need. We do not intend to phase out the postdoctoral fellowship training for researchers. Only the predoctoral.

MENTAL HEALTH CLINICAL TRAINING

Mr. FLOOD. You are using the phrase all the time "phaseout." Once again, this budget here calls for the phaseout, if you want to call it that, of the clinical training program. Last year we were told—I thought you were going to break down and cry—there was a shortage of mental health workers. Do you want to revise that statement, and revise your estimate of the manpower requirements that you gave us last year, in view of what you are going to do here with the cut?

Mr. ISBISTER. No; I would not revise the manpower estimates, sir. As a matter of fact, a very careful look is being taken at those manpower estimates now. Our estimates have been somewhat higher than those of the Health Resources Administration for the fields for which we are responsible.

I would like to point out that the proposal for phaseout is based upon the argument that the Federal Government undertook a special initiative to increase the number of people in the various disciplines which support mental health, alcoholism, and drug abuse, particularly mental health, because they were behind. As a result of those Federal programs over the last 15 years or so, there has been a spurt in the development of psychiatrists, clinical psychologists, psychiatric

nurses, and social workers. To a substantial extent they have caught up. The proposal is also based on the fact that there are alternative sources of support which can be obtained through loans, and through some of the expenditures of State and local governments, part of which are supported through our formula grant programs. And in addition, particularly in the medically related disciplines, in our case psychiatry, there is an opportunity to finance part of the clinical residency through third-party reimbursements. The salaries of many of these types of staff are paid by using third-party reimbursements which are collected for services provided.

Mr. FLOOD. Do you have any data at all showing how many of the people who are trained in this clinical training program actually go to work in the community mental health centers, or in State mental hospitals, or who do public health work?

Mr. ISBISTER. Yes, we have some data of that sort.

Mr. FLOOD. All right. If you do, we want you to put that in the record. And while you are doing it, in that statement, identify each one of those professional groups—psychiatrists, psychologists, et cetera.

Mr. ISBISTER. We will be pleased to provide that for the record.

MANPOWER MALDISTRIBUTION

Mr. FLOOD. Doctor, isn't it true that we have a very serious maldistribution problem with mental health manpower? Just as we do with all medical manpower?

Mr. ISBISTER. Yes, sir, it is true. It is a source of great concern to us.

Mr. FLOOD. All right.

How many of the individuals trained under what you call your clinical training program go to work in medically under-served areas? This has become a great subject, all through the country. Or have joined the National Health Service Corps? How many?

Mr. ISBISTER. I will have to ask Dr. Brown to respond to that.

Dr. BROWN. I don't think we have the figures. We will provide general information for the record along with similar information on employment of persons trained in our clinical training program.

Mr. FLOOD. All right.

[The information follows:]

Place of Primary Employment for Former NIMH Trainees

(Stated in terms of percentages)

| Place of Employment | Psychiatry | Psychology | Soc. Work | Nursing |
|---|---|---|---|---|
| 1. Treatment Institutions: | | | | |
| a. Hospitals & other inpatient treatment | 18.0% | 15.0% | 21.0% | 38.0% |
| b. Mental Health centers | 13.0 | 13.0 | 17.5 | 12.0 |
| c. Clinics | 3.0 | 5.0 | 21.0 | 4.0 |
| Subtotal | 34.0 | 33.0 | 59.5 | 54.0 |
| 2. Private or Medical Group Practice | 47.0 | 8.0 | 4.5 | 2.0 |
| 3. Teaching Institutions: | | | | |
| a. Colleges & Universities | 1.0 | 40.0 | 12.5 | 13.0 |
| b. Medical schools | 14.0 | 6.0 | 1.0 | 24.0 |
| c. Other health prof. schools | 0.3 | 1.0 | 1.0 | * |
| Subtotal | 15.3 | 47.0 | 14.5 | 37.0 |
| 4. Research Organizations | 0.4 | 2.0 | * | * |
| 5. School systems | 0.3 | 5.0 | 8.0 | 2.0 |
| 6. Courts & correctional institutions | 1.0 | 1.0 | 4.0 | * |
| 7. Others | 2.0 | 4.0 | 9.5 | 5.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

* Rounds to less than 0.05 percent.

NIMH has given major attention in its mental health clinical manpower development programs to the needs of under-served areas. This priority was identified in the NIMH Forward Plan for FY 1977 - 81. It is to be of particular concern in future NIMH programming, and has received similar focused attention in our announcement inviting training grant applicants for FY 1976 support. Institute efforts have resulted in the development and funding of a number of new training projects specifically addressing the needs of under-served areas. They have also led to increased attention, within on-going projects, to these concerns. In this regard, NIMH has been successful in insuring that to the extent possible, under-served areas receive special consideration in the location of training sites and in the field placement of trainees. Under-served areas then receive direct benefit from services provided by such trainees and gain indirectly in many ways through closer collaboration with institutions developing service manpower.

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Dr. BROWN. I will just briefly say that many have gone to work in the mental health centers established in areas where no mental health services previously existed. This has rectified some of the maldistribution.

Mr. FLOOD. I am also going so say that a great majority of the psychologists and psychiatrists are working in about six metropolitan areas in the country, too—the great majority of them. Is that correct?

Mr. ISBISTER. That is certainly true, Mr. Chairman, and that is a great concern of ours.

Mr. FLOOD. And of ours. That is why I asked the question. Well, Doctor, do you have a plan for solving this maldistribution of mental health manpower?

Mr. ISBISTER. We have a group that is at work within our——

Mr. FLOOD. Do you have a plan?

Mr. ISBISTER. We do not have a precise plan.

Mr. FLOOD. Why not?

Mr. ISBISTER. Because we have been in the position during each of the last 4 years of planning for the phaseout of these clinical training programs. Every year they have been restored, and they are restored substantially as they were in the previous year.

Mr. FLOOD. Why should the people who live in the underserved areas have to pay taxes, if they are not going to get any benefit out of this thing?

Mr. ISBISTER. I quite agree with you, Mr. Chairman. It is an issue which is under discussion within the National Institute of Mental Health, and by a group chaired by Dr. Waldrop within our administration, so we can pose policy alternatives and options for the consideration of the future development of these clinical research training programs.

Both the Congress and the administration are searching for new policies for Federal support of health manpower, particularly to provide appropriate incentives to deal with the problems of maldistribution of manpower. We are considering a number of options. We have no specific plan or proposal. But we hope to have one fairly soon.

Mr. FLOOD. All right.

DRUG ABUSE TREATMENT CAPACITY

Also in your statement you said the National Institute on Drug Abuse is going to increase its treatment capacity by 7,000 slots. That is going to bring your total to 102,000 persons who could be treated at any one time. That being so, how many individuals overall will be treated for drug abuse during fiscal year 1977 under this program?

Mr. ISBISTER. We estimate 174,000, approximately.

Mr. FLOOD. OK. Then what percentage of the total demand for treatment on this program are you going to be able to meet in 1977?

Mr. ISBISTER. Relatively speaking, our largest investment in support of treatment is for drug abuse. And we estimate that the National Institute on Drug Abuse supports somewhere around 30 percent of the country's total treatment capacity for drug abuse. For treatment of heroin addiction, NIDA's percentage of total national

support represents even a larger percentage, on the order of about 45 percent.

Mr. FLOOD. Who is going to provide the treatment for the balance of the individuals requiring treatment?

Mr. ISBISTER Currently some support is coming from other Federal agencies. And there is an increasing amount of support from States and localities. We have——

Mr. FLOOD. Localities?

Mr. ISBISTER. The States and localities, cities. Approximately 42 percent of the Nation's slots are supported from non-Federal funds. Furthermore, if you take the number of treatment slots that we support, for the 102,000 that you referred to, Mr. Chairman, we do not support 100 percent of the cost of those slots. We support something on the order of 62 percent. The rest of the support is obtained from State and local sources.

PREVENTION

Mr. FLOOD. We spend a lot of time talking about treatment. Possibly even of greater importance, is prevention, with a capital "P."

All right—how much are you going to spend on prevention programs in 1977, and what kind of prevention activities are you going to support?

Mr. ISBISTER. You are referring to drug abuse?

Mr. FLOOD. Both alcoholism and drug abuse.

Mr. ISBISTER. For grants we proposed $3.7 million in fiscal 1977 for drug abuse, and $2.3 million for alcoholism although the alcoholism funds will be included within the bloc grant proposal. I should also point out that both Institutes carry out extensive prevention programs in their respective clearinghouses.

Mr. FLOOD. Are you working with the Office of Education?

Mr. ISBISTER. Yes, sir.

Mr. FLOOD. At the Federal level, and also at the State and local level as part of this prevention effort?

Mr. ISBISTER. Yes, sir. I think the way to characterize the division of labor is that the National Institute on Drug Abuse has worked on the development of curriculum materials and informational materials which can be used in the public school setting.

Mr. FLOOD. What kind of prevention? What do you mean by prevention?

Mr. ISBISTER. I think the way we are using it here, we are talking about primary prevention.

Mr. FLOOD. What does that mean?

Mr. ISBISTER. By primary prevention we mean getting to individuals before they become afflicted with the problem. In other words, to try to get to people so they do not begin abusing drugs or alcohol. We have had some very interesting demonstration projects which either Dr. DuPont or Dr. Noble might want to describe at some length. These are local community demonstration projects, many of which are designed to work with youth groups. One of the things that is very clear is that it is the peer group which very largely affects the behavior of teenagers. The question is how you can permeate and work within the peer structure to affect the behavior of children and youth.

WHITE PAPER ON DRUG ABUSE

Mr. FLOOD. In addition to your treatment and prevention programs, what else did this Domestic Council's white paper on drug abuse recommend?

Mr. ISBISTER. They made a number of recommendations. I would like to ask Dr. DuPont to elaborate.

Dr. DUPONT. There were a broad range of recommendations, which included the law enforcement area as well as the health area. But let me focus just on the health aspects. One major recommendation was to increase the Federal investment in treatment, which is reflected in the 7,000 new slots for which funding is requested in the budget. Another was to increase support of demonstration programs in the barbiturate and amphetamine abuse area and in the vocational rehabitation area.

Mr. FLOOD. How long have you been at this—about?

Dr. DUPONT. I have headed the Federal Government's drug abuse prevention effort for about 2½ years.

Mr. PATTEN. You have been in the city longer than that.

Dr. DUPONT. Yes, Mr. Patten and I are old friends. I directed the District of Columbia's drug abuse program for 4 years prior to coming to the Federal Government. And, of course, I appeared before the congressional appropriations committee each year in that role.

DRUG ABUSE TRAINING PROGRAMS

Mr. FLOOD. Now, Doctor, your budget request calls for a reduction, $6 million this time, for training drug abuse treatment personnel. I gather this shifts the responsibility to the States—it must. What assurance do you have that the States are going to provide that kind of support?

Dr. DUPONT. Well, I think this reflects what Mr. Isbister was describing——

Mr. FLOOD. What makes you think the States are going to do that?

Dr. DUPONT. I don't expect the States will pick up all the activities we are now carrying on in the training area. As a matter of fact, in the training area there is a shortfall in terms of our ability to maintain continuation costs from grants awarded in the 1976 budget. This shortfall totals about $3.4 million. There is no expectation that the States would cover that deficit. So this budget was not developed on the assumption that the States will assume the responsibility for those projects which would otherwise have been funded by the Federal Government.

Mr. FLOOD. We get the impression you are shifting the responsibility for the training to the States.

Dr. DUPONT. We are also doing that, and I think that the States are increasing their commitment to training

Mr. FLOOD. I am speaking specifically of training.

Dr. DUPONT. I understand

What I am trying to say is that the States' increased concern over their training needs has resulted in their providing increased support in the training area.

However, I do not believe anybody assumes that the States are going to pick up all the slack that is created by this budget decline.

Mr. ISBISTER. One of the things that has been helpful in terms of the increasing State attention to the training needs for drug abuse has been the program where the National Institute on Drug Abuse has supported a small statewide training coordinator program in each of the 50 States.

EFFECTIVENESS OF DRUG ABUSE TREATMENT

Mr. FLOOD. Doctor, have you conducted any studies at all for the purpose of assessing the long-term effectiveness of this drug abuse treatment?

Mr. ISBISTER. Yes, sir; we have a data-gathering system that we are quite proud of which looks at what happens to people who enter treatment, and what happens as they complete or continue this treatment. It is called the client-oriented data acquisition process.

We have followed up on clients in treatment at 6 months. However, we would like to conduct a more comprehensive, long-term evaluation. In this particular budget, as a matter of fact, we are requesting $2 million to follow up people who have been in treatment and have left.

Dr. DUPONT. The first assessment will be one year after treatment. We will also have a 3-year posttreatment followup.

Mr. FLOOD. Do you have any solid information on which treatment or rehabilitation technique is the most effective? I know there has been considerable controversy over the choices.

Dr. DUPONT. We have some evidence in terms of cost-effectiveness.

Mr. FLOOD. I am talking about treatment.

Dr. DUPONT. We can say, Mr. Chairman, that there is no one treatment that is universally effective. I think, for that reason, it is very important that we support a range of treatment alternatives.

Mr. FLOOD. Mr. Michel.

REVIEW OF RESEARCH PROPOSALS

Mr. MICHEL. Thank you, Mr. Chairman.

Dr. Noble, and Mr. Isbister and Dr. DuPont, the chairman has covered pretty well many of the areas in which I have been interested, particularly figurewise. I should therefore like to devote most of my period of questioning to the area of drug abuse.

I posed a series of questions to the NIH people when they were here on the peer review system, of approving research grants. And since the Alcohol, Drug Abuse, and Mental Health Administration has about $130 million of research money here, I am going to ask the same questions of you, because I think it is important we have a complete understanding of the inner workings of this system.

In the first place, how many separate review panels do you folks have?

Do you know off hand?

Mr. ISBISTER. Eighteen.

Mr. MICHEL. About how many grants on the average do they review and approve?

Mr. ISBISTER. The number varies substantially from review committee to review committee.

On the average, however, approximately 150.

Mr. MICHEL. Who selects the members of these panels?

Mr. ISBISTER. The members of the initial review groups, the study sections, are selected by the Institute Directors in each of the three Institutes. The National Advisory Councils, which conduct the second level of review ,are appointed by the Secretary of HEW.

Mr. MICHEL. And where do these individuals selected usually come from?

Mr. ISBISTER. I think most of the members of our initial review groups, with a few notable exceptions, come from academia.

Mr. MICHEL. Is there any basic criteria used to govern the selection of these individuals?

Mr. ISBISTER. There are a variety of criteria.

The first and paramount criteria would be scientific competence to review the particular subject field. And in some of our areas, it involves multiple competencies.

For example, in the case of certain of the drug or alcohol reviews—you would need people from different disciplines—some from biochemistry, some from sociology. We apply other criteria as well. For example, we have worked very hard to increase the minority representation on our review committees at all levels. We are also concerned with the representation of women on these committees.

Mr. MICHEL. Again, I hope other than being a woman, she has some competence.

Mr. ISBISTER. That is correct.

Mr. MICHEL. The same thing with respect to minorities, I assume there is some competence to make a decision, and not some quota system you are trying to fill out.

Mr. ISBISTER. That is correct. That is why I underscored the first point. The first criterion is the competence, scientific competence, to discharge the review.

Mr. MICHEL. That ought to be controlling, all controlling—competence.

Mr. ISBISTER. Yes, sir.

Mr. MICHEL. Do any of these individuals sit on more than one panel?

Mr. ISBISTER. No.

Mr. MICHEL. That is with assurance.

Mr. ISBISTER. That is the rule.

Mr. MICHEL. OK.

Now, the other questions in this regard I am going to submit for the record rather than take up the time of the committee.

Mr. ISBISTER. There is one exception to that, Mr. Michel, the statute establishing the three member advisory panel which advises me requires that the panel members be appointed from the three advisory councils of the three Institutes. That is the only exception.

### MARIHUANA STUDY

Mr. MICHEL. Now, moving to this so-called sex-pot study—we, of course, discussed this to a certain extent with Dr. Cooper when he was here. But I would like to probe it a little more here in an effort to find out just how the original decision was made. I get the feeling that ADAMHA treats the necessity for obtaining immunity and confidentiality from the Justice Department for the use of a drug, in this and similar cases, as a routine matter, with an automatic approval expected. Is that a correct assumption on my part?

Mr. ISBISTER. Our experience in the past has always been that that approval has been routine. That is to say, the FDA–NIDA committee meets and agrees that a research project meets the criteria for use of controlled substances, and the recommendation is made to the Justice Department.

In the past, all of the determinations made by the Justice Department to the best of my knowledge have been routine—almost ministerial. But as Dr. Cooper indicated in our hearing here a week or two ago, the Deputy Attorney General has asked the Secretary to take another look at this project, and that is what we are doing.

We have scheduled an entire day to do that on March 11. Following that meeting, we will make recommendations to the Secretary, but only after exploring the full range of issues with respect to this project.

Mr. MICHEL. Well, maybe during the exchange of questions and answers here, we can help him come to some kind of decision at that time.

Why was $61,735 of this particular grant disbursed to Southern Illinois University before the Justice Department granted immunity?

Mr. ISBISTER. As Dr. Cooper indicated in his testimony, we on occasion disburse grants so that investigators can begin.

Mr. MICHEL. That was taking a chance, was it not?

Mr. ISBISTER. Yes. I think in the light of what happened on this project, which is unique in our experience, we should reconsider our policy.

Mr. MICHEL. That is one reason I am going to be developing this far beyond what I personally feel is appropriate to the total of $121,000 involved. But in your shop, with $130 million in research funds, in the National Science Foundation with half a billion dollars, in NIH with hundreds of millions of dollars—there is a principle involved here. And we better have it all out right now and above board, and discuss it fully. And then everybody is going to be a little bit better informed as to how they ought to proceed in the future.

### IMMUNITY CLEARANCES

Now, is it standard procedure to begin disbursing grant money before final approval in the form of immunity is granted? And if it has been heretofore, if that is the case, say so. I do not want to put words in your mouth. I gather it has been kind of lightly considered up to this point—as you say, pretty much routine.

Dr. DUPONT. I was a little concerned about Mr. Isbister's use of the word "routine," because it has two meanings in this situation. First, he is absolutely correct in saying that in the past approvals have been predictable; that is, the Justice Department has accepted the DHEW recommendations and granted approval based upon these recommendations.

In that sense, the clearance has been routine. However, the DHEW project review itself is definitely not routine. And that thorough review did go on with this S.I.U. project.

Now, you did raise a question that frankly I had not addressed before; the question of issuing a grant award prior to receiving all clearances. And the reason I think I had not addressed that issue is because in the past the Justice Department approvals have usually

taken no more than 30 days to obtain. Therefore, we have not had a situation before in which the approval of the grant and the granting of immunity have been separated by a long period of time—with one other exception. So I think you are right, that incident is causing me to rethink our award policy.

Mr. MICHEL. Do you know off hand how many of your grant requests or grants to be approved would have to be sent over to the Department of Justice for approval of immunity?

Dr. DUPONT. Between 5 and 10, per year.

Mr. MICHEL. You can correct that for the record and make it precise.

Dr. DUPONT. Last year the National Institute awarded five research grants whose principal investigator requested certificates of immunity from the Justice Department's Drug Enforcement Agency.

Mr. MICHEL. I have been advised by some legal authorities that even if the sex-pot grant receives final HEW approval, and immunity from the Justice Department, that this immunity will still not protect the university, the researcher, nor the participants from being prosecuted or sued pursuant to State obscenity statutes for the showing of obscene films for the purpose of sexual arousal. Was this possibility given any consideration when this grant was approved?

Dr. DUPONT. Mr. Michel, I would like to point out that the research techniques that are used in this particular project are not unique.

For example, the use of pornographic films to stimulate sexual arousal as part of a research methodology has been a standard technique for more than a decade. In fact, the congressionally authorized Commission on Pornography used this as a standard technique in its studies in this area which were funded at over a million dollars.

So the use of this technique is not in itself new. What is new is the study of this behavior when linked with use of marijuana. This has generated considerable publicity and public concern. That is new and is causing us to review our previous decision.

You also raised the question about prosecution. Other researchers, who over the last decade have used erotic films as a stimulus in their research methodology, have not had reason to fear prosecution. That simply has not been a problem. For that reason we did not anticipate it being a problem in this study. It has now become one and we need to look into it.

PROTECTION OF HUMAN SUBJECTS

Mr. MICHEL. Now, in ADAMHA's guide for the protection of human subjects, it states on page 33 that HEW is concerned with the protection of rights and welfare of the human subjects in all research. And then it goes on to say that the Department's regulations "are concerned with the protection against physical, psychological, sociological or legal risk."

Now, in an effort to carry these regulations out, doesn't the Department require all grant proposal requests to describe and assess any potential risks, including these physical, psychological, physiological, social, legal or others—assess the likelihood and seriousness of such risks, as well as analyze the risk benefit ratio here?

Dr. DUPONT. Yes, sir. That is done by two groups.

Initially, it is the responsibility of an initial review group. It is also the responsibility of the joint FDA–NIDA committee to make a second and independent assessment.

Mr. MICHEL. I did not read in that grant application, however, that the obscenity issue was really dealt with in that.

Dr. DUPONT. In terms of risk to the subjects?

Mr. MICHEL. Right.

Dr. DUPONT. You have raised today the risk of prosecution for pornography violations. I am not sure that risk was fully addressed. I would like to point out, however, that the films to be used in this project are to be purchased from the local distributor in Carbondale. These same films are being shown in the movie theaters in Carbondale. These are not New York or Paris films or films of a particularly unique nature. They are Carbondale films, Each of the subjects who is going to be shown these films will state in advance that he has previously seen similar pornographic films. This is done as part of the study's effort to avoid unnecessary psychological risk. So I cannot see how there would be a unique stress induced by the stimulus itself. However, the risk of local prosecution is another matter, although to my knowledge none of the Carbondale theater owners or patrons has been prosecuted previously for viewing or showing these films.

Mr. MICHEL. In light of the enormous coverage of the press, what guarantees has the applicant provided to human subjects in the required attachments in the grant request to insure that confidentiality will be maintained?

Dr. DUPONT. I do not know. That is something I will look into and submit for the record. One issue that I think can be quite useful to us in terms of the review we are going to have next week, is whether the publicity surrounding this project will influence the behavior of the volunteer patients to the extent that the project's objectivity will be jeopardized. That is an issue we are going to deal with next week.

[The information follows:]

The applicant has followed all standard procedures for guaranteeing the confidentiality of individuals participating in this study. These include written assurance, for approval by the Department of Health, Education, and Welfare, that confidentiality rights will be protected; and a certificate of confidentiality from the Justice Department which will protect research subjects from potential legal action to obtain personal or private information.

The applicant has taken a number of specific steps to guarantee strict confidentiality of the identities, histories, and data recorded from research participants. These measures include coding results of medical and psychological examinations, and other individually identifiable information, and keeping this data in locked files. This data will be used only by the principal and coinvestigators for purposes of conducting the study and disseminating its results to the scientific community. Any information that could possibly be used for individual identification will be destroyed prior to publication or other districbution of the results.

The experimental chamber itself will be a private, sound-attenuated room, with access restricted to the principal and coinvestigators. Furthermore, at the outset of the expediment, all subject will be fully informed of the nature of the experiment, including those steps taken to guarantee confidentiality. Ample opportunity will be provide for withdrawal of any potential subject prior to onset of the experiment if he judges the proposed safeguards to be inadequate.

COMMUNITY OPINION

Mr. MICHEL. The grant proposal stated the applicant checked out local opinion and found no serious objection. On the other hand, we have received reports which show no indication the community was ever contacted.

Dr. Cooper told us when he was here that this matter will be checked out, but as part of the rereview of the grant. I assume, then, it really wasn't checked out as part of the initial review.

Dr. DuPont. Well, it is my understanding that Dr. Joseph Brady and Dr. Jonathan Cole, who carried out the site visit, did talk to a number of local community people, and that Dr. Rubin has contacted quite a few local citizens as well.

However, there is some concern, on our part, Mr. Michel, about again protecting these citizens from adverse publicity should we openly provide their names. For example, a number of clergymen have suggested to Dr. Rubin, as I understand it, that they would rather not have their names be part of the Congressional Record as supporting this project, simply because they do not want to have the kind of obscene, hostile telephone calls Dr. Rubin has had about this project.

If there would be some way for us to provide to you or to a member of your staff information about these people in a way that would protect their anonymity, we would be very happy to do so.

Mr. Michel. My cursory review was there were not these kind of contacts you would normally expect to have in sampling a community. I mean just having a few of your people out and sit down, in Dr. Rubin's country cabin with a couple other university people, let's face it, is not checking out the community.

Dr. DuPont. I agree, Mr. Michel, if indeed that was the way it was done.

Mr. Michel. It appears cut and dried beforehand.

Now, when you say you are going to check for sure what the feeling is in that community, I have got to assume you are going to abide by the regulations.

If you want to abort the regulations, we ought to know about it, because if the only kind of comunity sampling you got was some meeting out with Dr. Rubin someplace in some country cabin, that is not checking out local opinion. And it ought to be corrected if it hasn't been done up to this point.

Dr. DuPont. I have been assured, and I feel confident, that a check was conducted that was much more comprehensive than the one you have described. And I would be happy to share the details of that process with you if it could be done on a confidential basis.

### SCIENTIFIC MERITS OF MARIJUANA STUDY

Mr. Michel. As a further indication of the problems you may be facing in this regard. I understand that a local suit may be filed to the effect that this was a misrepresentation in the grant application. So take that into account in your final deliberations on this rereview.

Now, I am not a scientist. I have said so. I am not an academician. I generally refrain from commenting on the scientific merits of the grant. However, we have received copies of materials submitted to HEW from scientists questioning the scientific validity of the project in a number of respects, and because of the nature of some of these questions. I am not going to go into them here.

Dr. DuPont. Yes, sir.

Mr. Michel. I am going to submit them for the record. I want you to respond as frankly as you can with good sense and propriety. But

there are some doggoned good serious questions raised, such as, what is the data base you begin with after you start smoking pot and all the other things—what base did you begin from? And I don't think in my review of that application there was that kind of consideration given to that. It is only from this point forward.

On good scientific ground, you have every reason to turn that thing down. It is not an infringement on academic freedom or anything else. It is on good scientific grounds, you can turn that thing down, and don't have to apologize to anybody. If you are afraid to do that, we are plenty willing up at this end of the table to take the kind of heat that you might have to take if such is the case.

Dr. DuPont. I would like to assure you that all of these questions you're talking about will be brought before the review group next Thursday. I would like the committee to know, we have taken pains to appoint people who have questions about the grant, and not just those who support it.

[The information follows:]

Insert page 3284 (a)

Questions for the Record Submitted by Mr. Michel on the Marihuana Study

Question. The grant proposal calls for "Experienced marihuana smokers" to participate in the research of the effect of marihuana on sexual arousal. How was the sexual potency of the subjects determined before they began smoking marihuana? Wouldn't such a determination be needed to serve as a base-line for comparison of sexual potency of "experienced smokers."

Answer. No subjects have as yet been tested. Pre-smoking baselines are not necessary because the study will determine acute effects only. This study will employ a single-subjects design, which means that participants will act as their own control. In other words, a change in a subject's responsiveness while under the influence of the drug and/or placebo conditions will be compared to his own baseline. Changes can then be related to the experimental conditions. This is a standard design used in drug experiments. In addition, use of placebo marihuana cigarettes and the counter balanced design in the study will allow the investigator to ascertain the effects of the drug on physiological, subjective, and biochemical response.

Question. Since you don't have a baseline for comparison, isn't it true that the participation of "experienced marihuana smokers" will not prove the effect of marihuana smoking on sexual arousal at all, but only the present status of the sex potency of the participants?

Answer. The study will only address the issue of the acute effects of marihuana on physiological, subjective, and biochemical response. As with any study, the criticism can be made that it does not go far enough, or answer all of the questions that could be posed. Dr. Rubin's study does not address the possible long-term, chronic effects of marihuana on sexual, subjective, and hormonal activity. Since this research study reflects the current state-of-the-art, the investigator is proceeding cautiously and studying the acute effects of marihuana on physiological, subjective, and biochemical responsiveness. Subjects must, by necessity, be experienced marihuana smokers because of the possible risks associated with exposing non-smokers to the drug.

Question. What guarantees are there in the grant proposal that assures the researcher that other drugs have not been taken by the "experienced marihuana smokers?" Would the consumption of other drugs, by the participants, affect the reliability of the results?

Answer. A detailed verbal drug history, as well as a biochemical analysis of body fluids, will be performed on each potential subject. These histories will be compared to findings on the analysis of body fluids. If discrepancies are found between these two different methods of determining drug usage, the potential subject will be eliminated from participation. In addition, a physical and psychological examination will be conducted on each subject. Those that have detectable instability, as determined by the Minnesota Multiphasic Personality Inventory and detailed psychiatric interview, and/or documented impotence, will not be allowed to participate. Other drugs, such as narcotics, might affect physiological response as measured in this study, but users of such drugs would not be allowed to participate in the experiment.

Insert page 3284 (b)

Question. To stimulate sexual arousal, would the viewing of the sex films be reliable because of the unknown behavior of the marihuana smoker when alone, in company, or under controlled conditions with various measuring devices attached to his body?

Answer. Reliability of the physiological measurements has been verified by a number of investigators as well as the principal investigator of the proposal under discussion. Pointing out that this experimental approach reflects the state-of-the-art, National Institute on Drug Abuse staff has queried Dr. William Masters, of the Reproductive Research Foundation in St. Louis, about the reliability of the methodology to be employed by Dr. Rubin. Dr. Masters indicated that the approach is both reliable and valid within the context of current scientific methodology used to study sexual responsivness in human males. A second issue is that of social setting and expectation factors as contributors to a drug's physiological, behavioral, and biochemical effect. Dr. Rubin's study will investigate subjects while they are alone in testing rooms. His investigation will address expectations such as instructions to retard or enhance arousal in the presence and absence of erotic stimuli. The setting is not a variable in the experiment. The presence or absence of others could be a factor that affects responsiveness; however, that assumption can only be verified by an empirical test.

Question. Isn't the sexual arousal that may result from viewing of sex films dependent on a wide variety of factors including formal education, home education, culture, religion, etc.? When you add another factor such as marihuana, aren't you confronted with too many variables to draw any reliable conclusions?

Answer. Sexual arousal is indeed dependent upon a wide variety of factors, but the issue of extraneous variables obscuring the findings and interpretation of such results is not unique to Dr. Rubin's study. Almost all biomedical and behavioral research is faced with such problems. With proper experimental design, however, such outside influences can be controlled. In Dr. Rubin's study, each participant's response will be compared to his own baseline measure. This approach will help keep cultural, religious, and socio-economic variables to an absolute minimum when the data are analysed.

Question. Attaching a transducer as described in the grant proposal to the subject might in itself be a constant sexual stimulation factor or a constant sexual inhibitor factor depending again upon the individual subject. Won't this tend to obscure the measurements that are necessary to obtain conclusive data?

Answer. The transducer methodology employed by Dr. Rubin in the present experiment is acceptable and scientifically valid in the context of the state of the art of measurement of human male sexual responsiveness. Drs. Robert Kolodny and William Masters of the Reproductive Biology Research Foundation have indicated to us that Dr. Rubin's approaches to the measurement of human male sexual responsiveness are clearly within the state of the art as it is practiced today.

The presence of the transducer can, in some subjects, act as a stimulus which leads to arousal; however, Dr. Rubin's published reports, as well as the work of other investigators, indicates that this arousal is a temporary phenomenon. The stimulating effects of placing the transducer around the penile shaft can last anywhere from 30 seconds to two minutes; after this period subjects adapt to the presence of the instrument. Due to this rapid adaptation, no measurement problem related to the possible stimulating effect of the transducer is envisioned; thus, the measurement of the physiological effect will be unrelated to this factor.

Mr. MICHEL. Now, Dr. DuPont, you were quoted in the press recently as indicating that research shows marihuana usage to be less dangerous than cigarettes or alcohol. It that an accurate quotation?

Dr. DUPONT. Well, that particular press coverage was a source of great distress to me.

Mr. MICHEL. I am the last one to believe everything I read in the papers.

Dr. DUPONT. The account that was published yesterday in the New York Times editorial page implying that I was encouraging people to smoke marihuana concerned me greatly.

I am firmly opposed, personally, to the consumption of marihuana, and I am committed personally to the Government's position of discouraging the use of marihuana. Having said that, though, I think it is important to realize that the Nation pays a very high social cost today for the consumption of tobacco and alcohol products, and as best we know, on the basis of currently available data, alcohol ranks as No. 1 in terms of social cost. Tobacco is No. 2 and marihuana is quite a distant third when these three most widely used drugs are considered. In any event, I think that marihuana is a health danger and its use ought to be discouraged.

Mr. MICHEL. I am happy to have that response, because I think you have clarified it here for the record.

Each member of this committee up here, and many I am sure out in the audience, day after day, are appearing before groups of young people. We want to give them forthright candid answers. By the same token, if it is not as bad as alcohol and smoking, but it is third or ranks third or some other thing, nevertheless, that certainly is nothing on the plus side to encourage its use.

Dr. DUPONT. Absolutely.

Mr. MICHEL. You are also quoted as saying that the report on marihuana "does not support the fear and irrationality that still characterizes some of the public debate about marihuana." I don't know if that is an accurate quote.

Dr. DUPONT. Yes; it is.

Mr. MICHEL. Is that a fair way to characterize concerns which many Americans have concerning the drug, particularly when research is still going on.

Dr. DUPONT. Yes. And the research that we have continues to show health problems associated with marihuana use. In other words, the research does not show marihuana to be a safe drug. I think the problem we have had with marihuana has been to try to inform the public, in a rational way that many people who smoke marihuana do not have any negative health consequences that we can identify, but also recognize that many people who use it do have problems. It is a little again like the problem with alcohol and tobacco. It is difficult to get across to the public that on the one hand many people have serious problems with alcohol and many others do not. And it is that kind of balance in presenting our findings about marihuana use that I am trying to strike. However, it is very difficult, because the public seems to think either you are saying marihuana use is a problem for nobody or for everybody.

I have been frustrated in trying to get across the concept that the marihuana issue cannot be simplified in that way.

INDIRECT COSTS

Mr. MICHEL. Mr. Isbister, do you know what the overhead cost is on an average of the grants from your shop?

Mr. ISBISTER. On average, about 35 percent of direct costs for research. For training grants, indirect costs are limited to 8 percent.

Mr. MICHEL. If you take an assessment of all the grants out at NIH, we have been able to determine it is roughly around 35 percent involved in overhead—in other words, indirect costs. Can you break that down similarly for those grants in your own shop?

Mr. ISBISTER. We have the data. I reviewed it the other day. I don't have it at my fingertips. I would be glad to provide such an analysis.

Mr. MICHEL. Feel free to do that, please.

[The information follows:]

INDIRECT COSTS ON ADAMHA GRANTS

The costs charged to ADAMHA grants are determined in accordance with applicable Federal management circulars and DHEW cost principles. This permits each grantee to treat certain costs as either (1) a direct cost charge to the grant, or (2) an indirect cost which is allocated to the grant based on a negotiated rate agreement. During the review process, the various review committees are aware of only the direct costs associated with the project. The indirect cost is a fixed rate applied only when the actual award is made. Depending on the accounting system of the legal applicant, these are costs of the project that are determined to be most appropriately paid by the central administrative unit rather than charged directly to the project itself. The rates are separately negotiated by the staff of the DHEW regional director for the region in which this legal applicant is located and apply to all grants made with the particular organization by any grantee within the DHEW.

For ADAMHA grantees the average amounts reported as indirect costs are as follows:

*Average indirect costs as percentage of direct costs awarded in fiscal year 1975 for ADAMHA grants*

| | *Percent* |
|---|---|
| Research grants | 34.35 |
| Training grants | 7.15 |

ADAMHA also administers financial assistance grants for community assistance, for example, treatment and rehabilitation services for alcoholism, drug addiction, and mental health. Less than one-fourth of these grants include amounts for indirect costs based on a negotiated rate. The average indirect cost percentage is slightly over 16 percent for those grants awarded funds on this basis.

The rates given above are, as indicated, the percent the indirect costs are of the direct costs. This method has been used since this is the way in which the rates are actually applied. However, it may be easier to assess their impact if measured as a part of the total grant dollars. In this case the percentages would be: (1) 25.57 percent for research grants; (2) 6.67 percent for training grants.

PRIVATE ALCOHOLISM TREATMENT PROJECTS

Now, moving for a moment to this alcoholism field, the chairman touched on, or at least posed, the question as to what was being done in industry. In my district, we have the Caterpillar Tractor Co., one of the large corporate entities in the country, doing a very marvelous job as a company in this field.

The director of it is a former classmate of mine as far back as high school. And we visited a number of times. He has made me very much

aware of the problem that has existed, and the kind of improvements that have taken place in their work record, throughout the plant, where it is near phenomenal, in the short period of time in which it has been underway.

The reason I raise the question—this is a management oriented, stimulated kind of program. But obviously it has to have the cooperation, in this case, of the United Auto Workers, big organized labor. I just would like to feel that they would help maybe in a financial way, even if it is just to recognize the validity of the program, and what good can be accomplished from it, and that it not all be management oriented and financed, but that labor as well recognizes there is an area of good contribution that could be made for the welfare and benefit of their fellow workers. I just have to applaud what Caterpillar has done from the standpoint of results up to this point. And if anybody needs a standard or some benchmark to follow, they have got it pretty much down to a real fine science.

Mr. ISBISTER. As I indicated earlier, Mr. Michel, the joint labor management committee that has been working under the chairmanship of Mr. Roche and Mr. Meany has been very successful in bringing labor and management groups together in various places around the country.

COMMUNITY MENTAL HEALTH CENTER GRADUATES

Mr. MICHEL. Now, one final thing, on the mental health centers. During the hearings on the supplemental I asked a series of questions with respect to distress grants, because it appeared that of those first 29 centers that were graduating out of the 8-year funding cycle, four were in real trouble, and then it appeared to me that in the next graduating class, the total was upwards of 50 or so. Somewhere along the line I got the view it was increasing, that we had moved to a point where maybe 30 percent were going to be in trouble, which then would be a bit at odds with your earlier statement there that maybe 10 percent eventually are going to be in that kind of trouble.

Now, have we got any better updated figures on that?

Mr. ISBISTER. Unfortunately, I was not at that hearing. Dr. Brown was. I personally have been surprised and delighted that it is a lower number of centers that end up in distress than I had anticipated earlier.

Mr. MICHEL. My concern is that if we are too lenient in bailing out those in financial distress, what is to inhibit the others, where with a little extra effort they could pull their own weight, from saying, "Shucks, let's do what our neighbor did, they just got bailed out by the Federal Government, let's us take that route." And before you know it, 50 percent of them are pleading poverty, and eventually the whole program kind of falls of its own weight, which would be disastrous, in my opinion. Do you have anything a little bit more encouraging there?

Dr. BROWN. I have something as encouraging farther down the pike. We have had a graduating class of 29 and 39, in 1974 and 1975 respectively, for a total of 68. But some of those still have some Federal funds left from their last grant award. We have 44 full graduates of which 10 percent are in serious trouble, and another 10 percent in moderate trouble.

The good news is that at the other end of the spectrum of those 44, 10 percent are still growing on State and local and private funds. If

you want, you can look at it as 70 percent in good shape or 30 percent in trouble. I agree with you we should only bail out the most seriously distressed.

Mr. MICHEL. Mr. Natcher.

ESTABLISHMENT OF RAPE CENTER

Mr. NATCHER. Why has not a director for the Rape Center been appointed, and why have you up to this time failed to start this center?

Mr. ISBISTER. Mr. Chairman, we have in a sense started the center.

Mr. NATCHER. To what extent have you, Mr. Isbister, started the center?

Mr. ISBISTER. Dr. Brown has had members of his staff working very hard over the last several months developing the program guidelines for that center, and developing the regulations and the methods of administration.

Because the administration has proposed that the funds included in the appropriation for the inauguration of the Rape Center be rescinded, we did not formally implement the program.

Now, with respect to the specific recruitment of an individual to head it, in the event that the rescission proposal is rejected by the Congress, I will have to ask Dr. Brown.

Mr. NATCHER. What about that, Dr. Brown? What about a director? Have you made any decision, or are —you moving along toward the selection of someone to be in charge of the Rape Center?

Dr. BROWN. Mr. Natcher, we have already several people that have asked about the position, have applied for the position, and we are going through a formal recruitment process for the position. Mr. Isbister said we are moving rapidly and slowly at the same time—rapidly in the sense of getting the guidelines and other pieces of paper out that would permit us to use the money if the rescission is rejected. And Mr. Miller may want to give us the word.

Mr. MILLER. The rescission does not run out until March 18. The committee has written and asked us to make the funds available before that. We currently have that under discussion with OMB. But the funds are not apportioned to the National Institute of Mental Health.

Mr. NATCHER. All right.

Dr. BROWN. We are between the rock and the hard place as usual—getting ready to do the job if the money is apportioned to us, and being asked why we are doing the job so slowly when the money is not apportioned to us. And no positions have been made available to us by the Congress, Mr. Natcher.

Mr. NATCHER. Dr. Brown, when it is apportioned, what about the time element then? How long it is going to take you?

Dr. BROWN. I think we will be able to spend the money well, constructively, with adequate review, hopefully by June 30.

We may have some possible spillover into the transition quarter. We will not spend the money unless it is adequately reviewed, Mr. Natcher

DISTRIBUTION OF MENTAL HEALTH WORKERS

Mr. NATCHER. Now, Mr. Isbister, I want to go back just a moment to the discussion you had with the chairman on the problem of maldistribution of mental health workers. Can you identify the area of

the country most in need of mental health manpower? What section of our country?

Mr. ISBISTER. It is predominantly the rural areas and the inner-cities that are in the worst condition, Mr. Chairman.

Mr. NATCHER. Have you given any thought to requiring the individuals that receive support under your clinical training program to serve in the National Health Service Corps, or to work in a State mental hospital, or a medically unserved area, Mr. Isbister?

Mr. ISBISTER. Those are three of the options which we have under consideration. As I described earlier, we have been talking about ways we can change the training program, so that it can be more responsive to the maldistribution problem. The kinds of models that we would consider would be similar to some of them that are included in the health manpower bill, having to do with requiring trainees to serve in areas of high need, such as those you have just described, or paying back the amount of Federal investment in their education. Those are two options we have under consideration.

### COMMUNITY MENTAL HEALTH STAFFING

Mr. NATCHER. Do all of the community mental health centers have full-time psychiatrists on their staffs?

Mr. ISBISTER. I will have to ask Dr. Brown.

Dr. BROWN. My impression is that the great majority, 80 or 90 percent do. There are some in rural communities that may have two or three part-time psychiatrists, that have program directors, such as psychologists or social workers, that make sure of adequate psychiatric coverage.

Mr. NATCHER. Is this one of the requirements, that a psychiatrist be on the staff?

Dr. BROWN. Yes; a psychiatrist must be on the staff, but not a requirement that the person be there full time. There is a requirement, of course, that there be medical and psychiatric coverage, both by Federal, State, and legal medical practice. But not full time.

Mr. NATCHER. Have you established a ratio of full-time professionals, such as psychiatrists and psychologists, that the centers must have for each 1,000 patients registered at the community health centers?

Dr. BROWN. We are developing these standards, but have at this point been investigating what is possible and feasible. For example, we would not want to set a standard that makes it impossible for a rural community to deliver mental health services. If you have a situation with one psychiatrist, say, in Montana, or Wyoming, serving 500 square miles, we would not want to set a standard that would not permit him to put half-time into the center, and to serve those people if he feels he has adequate backup and support from his psychologist, social worker, and other mental health colleagues.

### CONVERSION GRANTS

Mr. NATCHER. Dr. Brown, as you know, the law extending the community health center program specified that the centers provide additional service in order to be eligible for continued Federal support. How many centers will be seeking conversion grants in 1977?

Do you have any idea?

Dr. BROWN. About a hundred.

PLANNING GRANTS

Mr. NATCHER. What is the status of the 20 mental health planning grants this committee provided funding for in fiscal year 1976?

Dr. BROWN. The same status as the other programs under Public Law 94–63. Regulations and guidelines are about to go out to the field, to award the grants contingent upon funding.

Mr. NATCHER. Can you tell us when you will be seeking operational funding?

Any idea?

Dr. BROWN. Well, for 1976—and again, Mr. Miller, you might help me——

Mr. MILLER. It is part of the same rescission package. The 45 days runs out March 18.

Dr. BROWN. We are planning fully to try to implement that again by June 30, or in the transition quarter. The issue, of course, is the funds available to carry out the continuation costs for the old program and the new program for which there is no provision in the budget.

That is the figure that Mr. Isbister answered Mr. Flood's question of the $41 million shortfall, to meet minimum continuation needs next year, assuming the blockgrant proposal.

Mr. NATCHER. Thank you very much.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr Shriver.

CENTERS WITHOUT FEDERAL SUBSIDIES

Mr. SHRIVER. Thank you, Mr. Chairman.

Dr. BROWN. Are there any community mental health centers in the country operating on their own, without any Federal subsidies?

Dr. BROWN. There are the 44 total graduates I mentioned to Mr. Michel. And there are——

Mr. SHRIVER. They all had Federal subsidies.

Dr. BROWN. These are the 44 that finished their 8 years or 5 years or 9 years.

Mr. SHRIVERS. We wouldn't have those today if it were not for the Federal subsidy, would we?

Dr. BROWN. I must answer honestly. I think we would have some—not nearly as much.

BLOCK GRANT PROPOSAL

Mr. SHRIVER. I received the other day a review of the administration's block grant proposal for consolidations. It says in here:

> To avoid disruptions in health services delivery, and to insure an orderly gradual transition under the Block Grant Program, direct federal grantees, such as Community Mental Health Centers, Neighborhood Health Centers and Alcoholism Programs, will be protected from large budgetary reductions during the first three years of the program.

And then it says that the grantees will be guaranteed at least 80 percent of their 1976 grant level in the first year and 50 percent in the second year and 25 percent in the third year. What effect does this have on the 8-year program that we have had all these years?

Mr. ISBISTER. The effect, Mr. Shriver, would be that if the block grant proposal is enacted, it effectively makes null and void the current program. That is to say, all of the 16 programs which are being proposed for inclusion within the block grant would no longer exist. However, as you have just stated, each one of the prexisting Federal grant-aided projects must receive at least 80 percent of the amount they had received in 1976, and then 50 percent the second year out, and 25 percent the third year out.

Mr. SHRIVER. Then in effect, many of those centers would not receive the Federal support which they have been led to believe that would receive.

Dr. BROWN. That would be the practical implication.

Mr. SHRIVER. On the first page of your statement, you say, "Gratifying inroads have been made on these diseases." You are talking about alcohol, drug abuse, and mental health problems.

Would you, for the record—not for discussion here—put in a number of these gratifying results?

Mr. ISBISTER. I would be pleased to do that.

[The information follows:]

ALCOHOLISM, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SIGNIFICANT INROADS

*National Institute of Mental Health*

NIMH researchers have discovered a method for studying brain functioning through indirect measurement of glucose consumption in localized areas of the brain. As a result of this discovery, scientists can now explore many heretofore unresearchable problems, especially the effects of various drugs on brain function and behavior.

The use of psychoactive drugs has had a direct effect on reducing the numbers of patients confined to State and county mental hospitals. The efficacy of lithium carbonate in the treatment of acute mania has been established. Studies have shown that maintenance therapy with this chemical decreased by half the recurrence of manic and depressive episodes in persons with manic depressive disease. Research efforts have been able to identfy the impact and effectiveness of other drugs such as amitriptyline, an antidepressant drug substantially reducing the relapse rate in recurrent depressive orders; chlorpromazine, which can help halve the relapse rate of chronic schizophrenics; and various phenothiazine drugs which assist in the treatment of acute schizophrenia.

The program of biological and development research has led to the development of the first practical and reliable technique for determining hearing impairments in infants as young as 6 weeks, greater ability in identifying youngsters with reading disabilities, and better understanding of the brain mechanisms underlying the behavioral effects of amphetamines.

From the mid-sixties, when the Community Mental Health Center program was begun, through fiscal year 1976, an estimated 635 community mental health centers will have received Federal funding. When in operation, these centers will serve approximately 87 million people.

*National Institute on Drug Abuse*

Chronic toxicity studies on naltrexone, a narcotic antagonist, and levo-alpha-acetylemethadol (LAAM), a long acting narcotic that may replace or supplement methadone, have demonstrated their potential use of marketable drugs for treating heroin addicts. Extensive clinical trials are planned in fiscal year 1977.

NIDA-supported research efforts have led to the development of sustained-release drug delivery mechanims which may improve treatment methods by reducing patient dependence on frequent clinic visits.

Another project has developed a new autoradiographic procedure for precise location of narcotic drugs in the central nervous system which is expected to lead to better understanding of the underlying mechanisms of drug abuse.

Through its community programs activities, NIDA has provided for full utilization of 95,000 treatment slots and has assured treatment program compliance with national treatment standards.

*National Institute on Alcohol Abuse and Alcoholism*

In the area of research, the NIAAA has twice prepared and submitted a comprehensive report to the Congress summarizing new knowledge in the field of alcoholism. The range of research topics addressed in these reports includes areas such as current understanding of the relationship of alcohol use to brain, liver and heart functioning as well as a possible relationship between excessive alcohol use and some forms of cancer. The Institute has also reported preliminary findings which suggest that alcohol abuse among pregnant women can cause physical deformities in their offspring, including heart defects, facial and limb defects, and overall growth deficiency as well as lowered intelligence.

Institute-created momentum has led to efforts by many States to decriminalize alcohol abuse under the Uniform Alcoholism Intoxication and Treatment Act, and to treat it as a health problem requiring rehabilitation and care rather than criminal prosecution.

Over the years, Institute efforts have led to the development of over 750 prevention and treatment programs at the grassroots level. The identification by the Institute of special high-risk populations has resulted in programs to reach these previously negelected segments of the Nation's population.

Above all, the Institute has shown that alcoholism is treatable. Client outcome data reported by treatment programs supported by the Institute show recovery rates of 70 percent for patients who had received treatment in alcohol treatment centers, based on an average of one ounce or less of alcchol consumed per day as a criterion for recovery. Fifty-four percent were reported abstaining from alcohol altogether. Treatment in these programs also results in a decrease in time spent in hospitals and jails, and these reductions in institutionalization rates are directly translated into significant savings for community health, welfare, and criminal justice systems.

TOTAL FEDERAL EXPENDITURES FOR DRUG ABUSE

Mr. SHRIVER. The amount in this request for attacking the drug problem is not all that the Federal Government spends in connection with the problem of drug abuse.

Mr. ISBISTER. That is correct.

Mr. SHRIVER. How much and where are those other expenditures?

Mr. ISBISTER. We estimate that in fiscal year 1977, the Federal Government will be spending about $490 million. The VA will be spending about $38 million. The DOD, about $58 million and the Department of Justice, about $24 million. And of course, our own request is for $248 million. Those are the principal components.

Mr. SHRIVER. In addition to those, there is a sizable amount we contribute to the United Nations for their program. There is a request for $42.5 million, which is a sizeable amount, for international narcotics control. There must be some others around.

Mr. ISBISTER. The Department of Housing and Urban Development will be spending about $4.8 million through its various programs, probably the Community Development Act, which can be used for drug abuse. The U.S. Department of Agriculture will be spending an estimated $1 million. And as you mentioned, the State Department also supports drug abuse programs.

Dr. DU PONT. And of course the Justice Department, and the Bureau of Customs in the Treasury Department. What Mr. Isbister is talking about are the Federal funds associated with the demand side of the drug problem. There is a substantial Federal investment, not quite as large as this—I think about $300 million total, directed at reducing illicit drug traffic and supplies. This includes activities supported by the Drug Enforcement Administration, the U.S. Customs Service, and other Federal agencies concerned with the control and supply aspect of the drug problem. This makes the total Federal investment in drug abuse about $700 million a year.

PROCEDURES FOR DETERMINING INDUSTRY COSTS

Mr. SHRIVER. That is what I wanted to bring out.

As I understood an answer a little while ago, you said 40 percent of the cost of research grants is overhead.

Mr. ISBISTER. I stated it was about 35 percent of the direct costs. It would be a percentage of the total cost of the grant.

I am going to be analyzing and submitting information for the record.

I should point out that we review grant applications on the basis of direct costs. The HEW Accounting Office, or by delegation other accounting offices within the Federal Government, actually determine what the indirect cost rate should be for the institution receiving a grant. We do not do that.

Mr. SHRIVER. It seems awfully high for overhead.

Mr. MICHEL. Would you yield?

Mr. SHRIVER. Yes.

Mr. MICHEL. That is really getting at the heart of what I am at here. Do you have any different standard or do you just succumb to the overall NIH criteria? Of course, if they are lower than what you are, I am for them.

Mr. MILLER. When you raised this the other day, I made the point that we established a single rate for an institution, and if there is an NIH grant or several NIH grants at Harvard, a grant from the National Institute of Drug Abuse or Alcoholism, the same indirect rate is paid for all those grants.

Mr. MICHEL. Are we using a percentage figure?

Mr. MILLER. Yes.

Mr. MICHEL. When was that last calculated?

Mr. MILLER. It is not a single percentage for every institution. We have a group in the regional office which goes out to each of the educational institutions and establishes an indirect cost rate for that institution based on the principles that are contained in the OMB circular that we discussed the other day. Thus, each institution has its own indirect cost rate, depending upon how it fits within the criteria in that circular. That rate is then applied to each of the Federal grants to that institution.

Mr. ISBISTER. There is one exception. That is for training grants where there is an overall limitation of 8 percent.

Mr. MICHEL. That is all I have.

Mr. FLOOD. Mr. Patten.

SUICIDE

Mr. PATTEN. I am glad to see our old friend, Dr. Brown, here.

You gave me a book on "Mental Retardation and the Law." And it was excellent. As a lawyer I say it was excellent in my judgment. There wasn't anything in it about suicides—how one handles an attempted suicide. I think that is a big topic. How many suicides did we have in the United States last year?

Dr. BROWN. We had counted 25,000; estimated 100,000. It is the 10th or 11th leading cause of death. In several groups——

Mr. PATTEN. The book was good. I don't have the time to write to you at length—because I am in committee all the time helping Chairman Flood—we don't get time to write these little pleasantries.

Dr. BROWN. Thank you very much. It is a nice way to get a compliment, Mr. Patten.

Mr. PATTEN. I need information about suicides. I don't find it anyplace. In your work, do you hit on it anyplace—does it come up, or is there no research?

Dr. BROWN. It is a serious but minor issue in the mental retardation field. In the mental health field, more broadly including alcohol and drugs, it is a very serious problem. For example, in college students, 5 or 6 million youngsters, it is the second leading cause of death.

Mr. PATTEN. The fellow who had the highest marks in my law school class committed suicide. He earned all the honors.

I don't understand it.

Dr. BROWN. Mr. Patten, one of the things that concerns me is that murder is catching up with suicide. Over the last 15 years the rate for murder had gone up to be equal to suicide.

Mr. PATTEN. That is one of our great problems in Washington. People seem to like to kill. In your line you know that, right? The Irish are bombing each other, the Jews and the Arabs. All my life they have been killing each other. They must like it, is the only thing I can figure out.

STATE CONTROL OF FUNDS

Mr. PATTEN. Are you the fellow who said we ought to cut out this stuff and let every state get block grants, and provide the states and local communities with greater flexibility? You did say that, didn't you?

Mr. ISBISTER. I was describing and presenting the proposal for the block grants, yes, sir.

Mr. PATTEN. Why didn't you carry it further when you get in there with the White House and the OMB? Say in the Defense Department, why don't we have block grants? Originally, if you want to go back 200 years, the states were afraid to give up their army to a Federal army. And a lot of them argued every State should have its National Guard, and be on top.

Now, we have a lot of money in that defense appropriation. Shall we give the block grants, and cut the budget?

Didn't that come up in your overall hearings on saving money?

Mr. ISBISTER. I have only been privy to the discussions on the health budget, Mr. Patten.

Mr. PATTEN. You were not in that, then.

Mr. ISBISTER. No, sir.

Mr. PATTEN. I want to tell you something. If you cut out the money for the only college in America carrying out an alcoholic research program, at Rutgers, I am going to fight in this committee as hard as I can to keep that money in there.

They used to have that research up at Yale. I really think the Irish built the Pyramids. Where else would they get the bricklayers? And the Irish may have been Egyptians.

Dr. NOBLE. Actually I went to Rutgers.

Mr. PATTEN. I saw that. Do you have any gut feelings about the alcohol program?

The only college in America carrying a program—we took it off Yale. Is that your line, Doctor?

Dr. BROWN. It was for 12 years, until there was a reorganization.

Mr. PATTEN. A reorganization. Well, I want to give you notice right here. If we get up here marking up this bill, you are talking about a feather in the breeze with your other programs. You did not mention the word "tobacco" except it slipped off your tongue in the room here. What do you think they are spending to tell the American people this is good? How effective are you in your work? How many ads are in this morning's Post? District of Columbia has the highest per capita consumption of booze. Why should I give you this money? It is a waste of time as compared to industry expenditures.

How effective is your work Dr. Noble? Do you think we are just throwing money away?

ALCOHOLISM PREVENTION

Dr. NOBLE. I think it is a problem of great concern, the prevention aspect. Obviously our Institute has concentrated on a lot of aspects including treatment. I think prevention is one of the toughest areas to work in our country.

Mr. PATTEN. Your justification says you are going to ask the YMCA and the JC's to help you educate the young people about the dangers of alcoholism—right?

Dr. NOBLE. That is only one way we are going to get at the problem. Advertisement is a great problem, especially when it is aimed at our youth and those people who can suffer because of these messages. I am concerned about that. I also think that the problem is great in terms of the other segment of the population not being involved—alcoholism has sort of been pushed to the side. The stigma is there.

Mr. PATTEN. What do you mean "pushed on the side?" You are reducing the money here for the only university in America that has a research program. That is the only point I am making. I can't get any place with you, right? I got to do my work in the committee. Maybe we will head for veto HEW No. 6. We have had five in my time. But we are on a collision course.

My State, if you give them block grants, is going to use every dime for the budget because of fiscal problems. They are not going to give me anything, not 1 penny, for the programs that you are cutting. So don't justify block grants or cutting out grants or clinical work on the grounds that my State is going to do it. I came down here as a New Dealer. I loved FDR; he talked about a different philosophy in health. I don't buy this new idea that my State is going to do it, and Alabama is going to do it, and California is going to do it. In my lifetime it won't be done that way.

We are working here at cross purposes.

I want this money in there, I want the increases that are necessary to counter inflation. I know how to fight alcoholism. I got notions about how to fight drug abuse. We have a lot of addicts. Tear your heart out. I know with our poor mentally retarded, this appropriation just goes backwards.

Mr. FLOOD. Mr. Roybal.

Mr. ROYBAL. Thank you, Mr. Chairman.

Due to the lateness of the hour, I am going to ask just a few questions, and then submit some for the record.

Mr. FLOOD. Without objection.

BUDGET DECREASES

Mr. ROYBAL. Now, without overburdening the subject—I would like to understand your position, particularly in view of the fact that I cannot correlate what you say with what you do.

You stated in your remarks that alcoholism, drug abuse, and mental illness are crippling realities for millions of Americans and their families, and a great burden to our economy. Then you go on and say that the relief of this pain and this burden "calls for our continued dedication and effort." Now, how much dedication and how much effort is there when you recommend a decrease in the overall budget of $188 million?

Mr. ISBISTER. Well, I think, Mr. Roybal, one of the principal elements in this discussion and dialog is the one that Mr. Patten was referring to, which has to do with the role of the Federal Government and the role of the States. To a considerable extent, this budget, particularly in relationship to the bloc grants, is governed by the desire to shift the administration of a number of programs to the States. The other principal determinant of the budget has been the overall fiscal problems that the country has faced. In that respect, our budget is not unusual. I suspect that many of the other budgets you have been reviewing here have been proposing similar kinds of decreases.

Mr. ROYBAL. That is perhaps true. But may I state that they are not half as convincing as some of your arguments in justification of some programs and on the other hand, asking that budget to these programs be curtailed. For example, I was very impressed when you said that alcohol abuse "not only brings suffering to individuals and families and wastes vast human potential, it also exerts a heavy financial drain on the country, a drain recently estimated at $25 billion a year."

Still the alcohol formula grants were decreased by $9.9 million, the community service projects were decreased by $54.3 million. You see, a lay person like myself, cannot understand how your arguments for something can be so persuasive for a program and at the same time ask to reduce the amount that is to be used to combat the problem.

Another very persuasive argument that you made. "The major mental illnesses continue to strike heavily throughout the population." And then you go on to say, "We estimate this constellation of problems costs the nation close to $40 billion annually." But you still recommend a decrease of $53.5 million. I don't understand this. If the problem is that great, why do you recommend a decrease?

Mr. ISBISTER. Well, part of the disparity in the budget, sir, I think is accounted for by the fact that the 1977 budget was originally based upon the President's recommendation for fiscal 1976.

Mr. ROYBAL. Then this is not really your budget, is it?

You have been told that this is the level of spending, and therefore you have met that level; is that correct?

Mr. ISBISTER. It is. And it is the President's budget which I am here to defend.

Mr. ROYBAL. You are defending it—but your heart is not in it. Am I correct, Right or wrong?

Mr. ISBISTER. Any of us who is responsible for a particular program in the executive branch obviously is an advocate for it. The record of the development of this budget shows that in the first instance we proposed higher levels than are in the final budget.

Mr. ROYBAL. That is the answer that I want. You are telling this committee that your expert opinion does not coincide with the budget's recommendations that you are defending.

Mr. PATTEN. I object to that question.

You think they want to get fired?

Mr. ROYBAL. I want to get on the record——

Mr. ISBISTER. I think the record is clear in terms of the history of the development of this budget. It has been submitted to the subcommittee by Mr. Miller's office. The President and the Office of Management and Budget were left with a set of very difficult choices that had to be made.

Mr. MILLER. May I just add a word? I don't think the issue between us is any disagreement with the professionals over the problem or the need to do something about it. The whole dialog and issue is how much is the federal—how much of the federal dollar should go for this particular problem? There is no quarrel within HEW or even with OMB about the problem itself or the need to do something about it.

Mr. ROYBAL. In other words, you do agree, then, with the figures that have been stated, that alcohol abuse costs $25 billion a year, the major illnesses, $40 billion annually.

Mr. MILLER. We have no separate data. The data tha twe use are the same data that come from the program.

Mr. ROYBAL. This is what bothers me. Financial experts prepare the budget, perhaps, and they do not listen to the experts in the field for which that budget is being prepared.

It is very much like architects designing a kitchen without talking to the housewife. And that is just about the parallel that can be made with regard to this.

Now, Mr. Chairman, I realize I am not getting anyplace with this discussion. So I am going to submit for the record questions with regard to the effects of economic crises, recession, and high unemployment, on mental health. And I would like to have those answered for the record.

Mr. FLOOD. Without objection, that will be done.

[The questions and answers follow:]

MENTAL HEALTH AND THE ECONOMY

Mr. ROYBAL. In its 1977 budget justification, the National Institute of Mental Health indicates that it will focus attention on problems related to "economic and work-related crisis." What studies have been supported by the Center for Studies on Metropolitan Problems and the Division of Epidemiology concerning the effects of economic crisis such as recession and high unemployment on the mental health status of workers and their families? What is NIMH's current 1976 and planned 1977 level of support in this area?

Dr. BROWN. Taking the last question first, our 1976 anticipated budget for this area comes to approximately $1.1 million, primarily in research grants. In 1977, we anticipate that we will be able to devote approximately $900,000 to this area.

We have supported several research activities that relate family mental health to the economic crisis. One of these tried to measure and predict social pathology in the community. These phenomena include mental illness, divorce, homicide, crime, and family dependency. We then tried to find out the relationships between these problems and unemployment. In the course of doing this work the researchers developed a subemployment index and found that these more sophisticated measures of unemployment were much better predictors of social pathology and poor community mental health than was unempolyment per se. In another project the researchers are undertaking an investigation of the ways in which individuals, families, and local communities respond to the twin threats,

pressures and stresses generated by inflation and high rates of unemployment. They are trying to identify some of the adaptive family and community responses to these stresses. Another researcher is extending his previous work, which related mental illness to changes in the economy, moving out from mental illness to study a whole variety of social pathologies and their relationships to the economy in 10 different cities. He is exploring such pathologies as mental disorders, crime, high mortality rates, family disorganization, impoverishment, and the like. A different kind of research being conducted tries to identify the consequences of and family adaptive responses to the expiration of unemployment benefits, in terms of physical and mental health, by looking at several major social support sources simultaneously. These sources include neighborhood, friends, family, and former workplaces. This work seeks to assess the impact of these social supports upon consequent labor market behavior.

Mr. ROYBAL. I understand that the Brenner study which was published in 1973, in part, financed by NIMH presented evidence that economic trends greatly influence the mental and physical health status of workers. Apparently, the rate of unemployment and adverse changes in personal income have most serious effects on our national health levels. On the basis of the Brenner study and other NIMH-supported research, what recommendations and programs has the Institute developed toward ameliorating this problem? Specifically what steps has NIMH adopted to insure that the federally funded community mental health centers are responding positively to this issue? What cooperative programs have been developed with State and local health agencies?

Dr. BROWN. With the National Institute of Mental Health, the Center for Studies of Metropolitan Problems has focused some of its concerns on informal systems of social support. The Center has directed part of its research resources at what happens to those large numbers of people, perhaps the majority, who cannot, or choose not to use professional mental health services. The Center will solicit related research for generating awareness of the results of the presently funded research.

In addition, the federally funded community mental health centers are required to provide mental health services to all persons residing in their catchment area regardless of ability to pay. This removes the financial status of clients as a deterrent to service.

The more significant requirement of community mental health centers is their consultation and education programs. This requires them to assist other community care givers such as social, welfare, and unemployment agencies in the community to be sensitive to factors about their clientele that may have mental health implications. The Community Mental Health Center Amendments of 1975 provides specific support for consultation and education programs.

The proposed draft regulations and guidelines for State Plans to implement the Community Mental Health Center Amendments of 1975 require States to identify factors within each catchment area which effect the mental health of the residents. The Public Health Service, National Institute of Mental Health and regional offices have provided technical assistance to State and local health agencies to enable them to identify groups within their populations who are at risk and may require mental health services.

Mr. ROYBAL. I understand that mental health studies have questioned the appropriateness of mental hospitalization in cases of economic stress. The Brenner study, for instance, concludes that such hospitalization "actually compounds the social impact of economic stress enormously * * * It closes off and isolates the individual from his normal social context." What health strategies have been developed in preventing unnecessary hospitalization? What role can the family and community play in helping persons facing economic stress?

Dr. BROWN. For large numbers of people the crucial determinant of how they will respond to job loss and other kinds of stress is the degree to which they can call on the informal support structures of family, neighbors, relatives, and fellow workers. The NIMH Center for Studies of Metropolitan Problems is now seeking, through research, to identify ways in which these informal systems at the local community level can be strengthened or even developed anew. The health strategy most helpful in preventing severe trauma, unnecessary hospitalization, and similar individual and family stresses would be to explore to the fullest possible extent the individual and social support networks that sustain people in times of trial and tribulation.

It is estimated that approximately 52 percent of clients seen at community mental health centers have an annual income of less than $5,000. The community mental health center consultation and education programs attempt to assist

community social, welfare, and employment agencies to deal with the problems their clients present directly and to avoid referral to a mental hospital. Many community care givers with mental health consultation, can deal with potentially severe mental health problems without having to refer to person to a mental institution. The Community Mental Health Center Amendments of 1975 require community mental health centers to develop screening programs for persons in their catchment area who are referred to mental institutions. This is to avoid inappropriate referrals and to prevent the compounding of personal problems with the additional problem of adapting to an institution.

Public Law 94–63 also requires the community mental health center to provide followup and transitional services for people discharged from State facilities. About 12 percent of the community mental health center case load is made up of referrals from psychiatric institutions. An important aspect of the followup is to address the clients job skills and income producing capacity. This, incidentally, is not a new requirement in that Public Laws 88–164 and 89–105 called for this service.

Mr. ROYBAL. Another area of concern is the elderly living on fixed incomes who are also affected by economic stress. What programs have been established to provide mental health assistance to the elderly for fiscal year 1976 and 1977? At what levels of support?

Dr. BROWN. The National Institute of Mental Health has a particular concern for the elderly with mental health problems. The 600 community mental health centers throughout the Nation cover catchment areas of 90 million people and each has an average operating cost of $1 million. These Centers have a variety of programs to meet the mental health needs of aging persons, such as depression, stress, and anxieties which come about as the result of altered economic life situations. The centers also collaborate with other agencies in the community for the delivery of supportive services for the aged.

The Institute has also funded projects which examine systems for the delivery of services to mentally frail aged persons in the community. One such ongoing project is taking place in New York City. The core of the project is a coffee house social center with extensive outreach. The purpose of the project is the development of a coordinated service to deliver physical, mental, and social supports to the mentally frail elderly in order to enhance their ability to remain independent. Those aged persons served include the elderly with altered financial states who are having difficulty in coping. The project will be evaluated as a model for sustaining mentally frail elderly persons in the community thereby reducing unnecessary hospitalization or delaying it until absolutely necessary.

The NIMH also has an active program addressing research, training and service needs and gaps in general as related to aging. The 1976 budget contains $4.8 million for research and training efforts related to aging and the fiscal year 1977 budget proposes $4.2 million for similar efforts. Additionally, as required by Public Law 94–63, the Committee on Mental Health and Illness of the Elderly is being formed to study and make recommendations to further promote our understanding of the special mental health problems of the aged.

Mr. ROYBAL. According to NIMH data, there has been, beginning in 1974, a significant rise in persons with suicidal symptoms who are unemployed. I understand that a survey conducted by the Disaster Assistance and Emergency Mental Health Section reveals "sizable increases" in the percentage of patients unemployed, and in persons mentioning unemployment as a reason for contacting crisis centers. What figures can you provide on these increases?

Dr. BROWN. We have figures for crisis calls from persons contacting crisis centers in 1970, 1974, and 1975. This survey was taken informally last year at Los Angeles, as well as centers in St. Louis, Detroit, and Nashville. It was a consistent impression from staff at these centers that crisis calls reflected the added dimension of economic problems. The Los Angeles survey indicated that the number of Center contacts per year increased from 6,000 in 1970, to 12,000 in 1974, and 16,414 in 1975. It should be emphasized that these data represent survey figures and are clinical impressions rather than those of a formal research study. It is my personal feeling that they are reasonably valid, however. The problem of suicide among younger age groups is particularly apparent and of special concern to us.

Mr. ROYBAL. What steps have been taken to monitor this situation?

Dr. BROWN. The Institute has specifically designated the Disaster Assistance and emergency Mental Health Section within our Epidemiology Division to maintain continued investigations into this area.

Mr. ROYBAL. With regard to suicide and the unemployed, what programs have you established for crisis intervention and emergency mental health?

Dr. BROWN. Direct services in the areas of crisis intervention and emergency mental health are provided through the community mental health centers. Research relating to the phenomenon of suicide is supported as part of our overall program on depression. In addition, NIMH is making a rather specialized effort to look into the possible connections between unemployment and mental health.

One project seeks to identify the effects of economic fluctuations on a whole range of personal and social pathologies over time. But unemployment is only one economic indicator with destructive implications for mental health. Other researchers are examining poverty itself, and the effects of differential labor force participation of women and minorities on the mental health of their families and communities. The concern with poverty and mental illness has led to investigations of the disparity between those who live in the economic mainstream and the almost separate worlds of the "dual economy," each of which functions with varying and often punishing impacts on individuals, families and communities. Among the major findings is that subemployment is a far better predictor of poverty and social pathology than the usual, narrowly defined measure of unemployment. Another major finding is that the quality of the adjustment to unemployment is largely determined by the presence and quality of informal systems of social support available to job losers. Indeed, one researcher has found that, for the majority of persons in need of help, these informal support systems, rather than formal health care agencies, are the primary source of mental health services.

Mr. ROYBAL. At what level of support?

Dr. BROWN. In the broad area of depression, of which suicide is a part, we are spending approximately $8,755,000 this year, and $8,124,000 in 1977. With respect to the more specialized area of mental health and the economy, we are spending $1,075,000 in 1976, and expect to spend $903,000 in 1977.

Mr. ROYBAL. How does this compare with previous fiscal years?

Dr. BROWN. We spent $8,536,000 in the general area of depression last year, and $938,000 on the more specific problem area of mental health and the economy.

Mr. ROYBAL. The reecnt Warren study, released in 1975 and supported by NIMH, concluded that "unemployment poses a most severe threat for women" especially in terms of stress and mental and physical health. The study strongly suggests the establishment of supportive community programs attuned to the mental health problems among women. What specific actions and recommendations have been adopted to implement these findings? What support will be given to this area in fiscal year 1977?

Dr. BROWN. In the National Institute of Mental Health, the Center for Studies of Metropolitan Problems has been looking for ways in which news informal support systems can be generated and existing support systems can be strengthened. In this connection, we have some projects which seek to identify the nature and structure of informal support systems, and to train urban populations to develop alternatives to current stressful patterns.

To implement these findings, the research and the services components of the National Institute of Mental Health are promoting awareness of the results of this research and recommending application of this knowledge in communities and neighborhoods. The Institute will consider this area for strengthened support in fiscal year 1977.

### CMHC FUNDING

Mr. ROYBAL. Given these findings and their serious implications for mental health, I am extremely concerned about the Institute's proposed 43 percent cutback in community mental health programs, from nearly $230 million in fiscal year 1976 to $130.8 million in fiscal year 1977. What program analysis has NIMH conducted on the effect of this decrease in the delivery of mental health services to the disadvantaged and unemployed populations? What written assurances has it received from the State and localities that they would be able to sustain the community programs? How many adults and children will be denied service in fiscal year 1977 as a result of this cutback?

Dr. BROWN. First, I would like to place the current-year level of $230 million in its proper perspective. Included in that amount are $53.5 million for the new community mental health centers legislation. The President's 1977 budget was based upon an assumption that these funds would be rescinded. This assumption, along with the bloc grants proposal which is being put forward for 1977, would have eliminated the need for continuation funding under this authority. In addition, $14.2 million included in this year's $230 million total represents prior-year funds carried forward under the community mental health centers construction program. These funds do not entail a continuation commitment. This means that

we are really talking about a current-year base of $162.2 million, representing staffing and child mental health continuation costs for projects approved under the old centers authority. The 1977 budget does, in fact, include sufficient funds to meet commitments to the latter program. The NIMH has not yet undertaken studies to determine the probable effect of the bloc grant proposal on the mental health delivery system.

Although we have no specific written assurances from center directors that efforts will continue to be made in supplying services, the network of mental health centers is firmly established and there is a commitment to meeting the mental health needs of the people. Further, it is anticipated that States will give priority to providing mental health funds as needed and as needs are estimated. In the event of a curtailment in services, we have no way of knowing the precise effect on numbers of adults and children receiving assistance from centers.

CHILD MENTAL HEALTH

Mr. ROYBAL. Studies have indicated the failure of mental health services to meet the needs of children from lower socioeconomic and minority backgrounds. One recent study funded, in part, by NIMH known as the Nova Bromet study suggests that mental health services for children can be significantly improved when offered in a neighborhood health center providing pediatric care, community input into services and outreach efforts. What current efforts are being made by NIMH to improve mental health assistance to children? What cooperative programs has the Institute developed with the Health Services Administration which supports community and migrant health activity and maternal and child health services?

Dr. BROWN. Children's mental health remains a high priority at NIMH. In the area of services, we are in the process of developing regulations and guidelines for the new CMHC legislation mandating children's services as required components of CMHC's. These regulations and guidelines will be such as to ensure that major efforts on the behalf of children will be made throughout the CMHC system.

We are also supporting services related research to develop innovative approaches to children and their special problems. For example, we are supporting projects that are developing assessment and intervention techniques for infants and their families. We are also establishing an informal national clearinghouse on the problems of high-risk infants and children.

Additionally, there are some special children's problems we are engaged in, such as child and adolescent abuse and neglect, the role of mental health in the EPSDT program, and sudden infant death syndrome.

Our child-related work with HSA has focussed primarily around the problem of sudden infant death, otherwise known as SID. We are represented on the interagency panel on SIDS, which meets periodically to share information, coordinate activities and provide mutual consultation. This arrangement has worked well and may provide a model for future efforts around subjects of shared concern.

We have also recently established a liaison with the National Health Service Corps which provides manpower to underserved areas. While not addressing the problems of children exclusively, the services provided through the Corps certainly include children as part of the recipient population.

Mr. ROYBAL. Since NIMH proposes a 24 percent cutback in community mental health programs for children from $26.8 million in fiscal year 1976 to $20.3 million in fiscal year 1977, how does the Institute expect to strengthen programs and services for this group?

Dr. BROWN. This reduction reflects the declining Federal match for these programs under the old CMHC legislation. However, child mental health is a required service to be provided by each CMHC under Public Law 94–63. In order to implement the law, the NIMH is striving to strengthen programs and services for children through increasing the emphasis on efforts for children in general CMHC programing. Draft regulations and guidelines now being developed are being utilized to provide such emphasis. They call for identifiable children's programs with earmarked dollar and staff resources, criteria for determining quantitative level of effort, and a comprehensive range of service elements for children.

The NIMH is also seeking to strengthen programs and services for children through research and development project support. These projects relate to the whole age spectrum of children and youth from infancy through adolescence and are concerned with a wide variety of service objectives including both prevention and treatment. In the area of prevention two examples of service related research

activity include a project which has developed ways of enhancing children's preparation for hospitalization and a project which is developing a tool for helping to identify potential problems in preschool children. In the area of treatment two examples relate to developing alternative services to institutionalization; one utilizes a cooperative living arrangement for troubled youth and the other utilizes a community-based program for children who would otherwise be hospitalized.

MINORITY EMPLOYMENT

Mr. ROYBAL. On another subject, will you please submit for the record a breakdown of your employment record listing each minority—sex and et cetera.

Mr. ISBISTER. I have some data for the Agency and I will be happy to submit it for the record.

[The information follows:]

BREAKDOWN OF ADAMHA HEADQUARTERS GENERAL SCHEDULE EMPLOYEES BY RACE, SEX, AND GRADE

[In percent]

| Grade | Other | | Black | | Spanish American | | American Indian | | Asian | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 210g | 2.0 | 0.3 | 0.2 | | | | | | 0.2 | |
| 18 | .3 | | | | | | | | | |
| 17 | .6 | | | | | | | | | |
| 16 | 1.1 | .2 | | | | | | | | |
| 15 | 15.9 | 2.6 | 1.5 | 0.2 | 0.2 | | | | .6 | |
| 14 | 15.4 | 4.2 | .9 | .6 | .2 | 0.2 | | | .5 | |
| 13 | 10.0 | 5.3 | 1.4 | 1.8 | .8 | .2 | | | .3 | |
| 12 | 7.9 | 7.3 | .6 | 1.5 | .2 | | | | | 0.3 |
| 11 | 4.8 | 7.1 | .6 | 2.6 | | | | | .2 | |
| 10 | .4 | | .1 | | | | | | | |
| 9 | 3.6 | 13.7 | 1.8 | 1.5 | .1 | | | | | |
| 8 | .7 | 3.8 | | .6 | | | | | | |
| 7 | 5.2 | 14.6 | 2.1 | 3.2 | | .3 | | | .1 | .3 |
| 6 | .6 | 14.6 | .7 | 1.7 | | | | 0.1 | | .1 |
| 5 | 1.8 | 11.7 | 1.1 | 2.4 | .1 | | | | | |
| 4 | .3 | 5.4 | .7 | 1.4 | | .3 | | | | |
| 3 | .7 | 2.2 | .1 | .8 | | | | | | |
| 2 | | .7 | | .3 | | | | | | |
| 1 | | | | | | | | | | |
| Total | 34.5 | 47.6 | 5.9 | 9.3 | .7 | .4 | | .1 | .8 | .3 |

Note: Percent slightly less than 100 percent due to rounding

MENTAL HEALTH CARE

Mr. FLOOD. Mr. Conte.

Mr. CONTE. Dr. Brown, what percentage of the cost of national health care is for mental illness?

Dr. BROWN. The cost of direct care including the expenses of prepayment through insurance for mental illness totaled $14.5 billion in 1974—equivalent to 15 percent of all health care expenditures in the Nation.

Mr. CONTE. What percentage of patients now seen by family physicians, internists, pediatricians, and other non-psychiatrist physicians have diagnosable mental illness?

Dr. BROWN. Currently available data on the prevalence of psychiatric disorder in general medical practice settings may be summarized in the following manner for adult patients age 15 and over. Approximately 5 percent of all patients who visit a general medical physician are undoubtedly affected by a primary psychiatric disorder which must be dealt with by the physicians as the most urgent condition of this patient requiring treatment. This minimal figure has been found in studies of visits to office-based physicians in the National Ambulatory Medical Care Survey study and in unduplicated patient cohort studies in various general medical care settings. In studies where primary care

physicians are either trained or sensitized to look for the presence of psychiatric disorder in their patients, it is found that 10 percent of patients may readily be identified as having a classifiable disorder. An additional 5 percent of patients in these settings are found to have emotional or psychiatric-associated conditions which are not readily classifiable by the international classification of diseases. Hence, approximately 15 percent of patients in general medical settings may be diagnosed as having a psychiatric or emotional disorder.

### NIMH STAFFING

Mr. CONTE. What kind of data could you furnish which would show how NIMH has fared over the past several years, with respect to ratio of staff to workload? I would also like to see this data projected to reflect your 1977 budget request.

Dr. BROWN. Because of the creation of ADAMHA 2 years ago, we will have to make several adjustments to achieve some degree of comparability. Generally speaking, our staff is responsible for over 60 percent more grant and contract dollars than they were 5 years ago. Funds appropriated for this purpose in 1976 are 29 percent higher than in 1971, while the staff who are related either directly or indirectly to the grants process has decreased by 21 percent. I will be glad to furnish this information for the record. We will include data for the period 1971 through 1977, along with the assumptions which we used to reach our conclusions.

[The information follows:]

NATIONAL INSTITUTE OF MENTAL HEALTH

TRENDS IN STAFF AVAILABLE FOR ADMINISTRATION OF GRANTS AND CONTRACT FUNDS

[Dollars stated in thousands]

| Fiscal year | Obligations grants | Contracts | Total [1] | 7H positions [2] | Amounts per MH positions |
|---|---|---|---|---|---|
| 1971 | $300,896 | $3,125 | $304,021 | 563 | $540 |
| 1972 | 321,444 | 3,630 | 325,074 | 535 | 608 |
| 1973 | 342,404 | 3,152 | 345,556 | 493 | 701 |
| 1974 | 386,775 | 4,151 | 390,926 | 461 | [3] 848 |
| 1975 | 392,217 | 3,320 | 395,537 | 404 | [3] 909 |
| 1976 | 389,205 | 2,758 | 391,963 | 444 | 883 |
| 1977 | 220,338 | 2,258 | 222,596 | 286 | 778 |

[1] To insure comparability of funds, obligations for drug abuse and alcohol programs have been deleted from those years when the latter were included as part of the NIMH budget

[2] To insure comparability of staff, the following deductions were made, as they do not relate directly to the administration of general mental health grants and contracts activities: (1) Staff assigned directly to the administration of drug and alcohol programs; (2) Staff assigned to the NIMH intramural research laboratories; (3) Staff assigned to the NIMH Mental Health Study Center and National Clearinghouse for Mental Health Information

[3] Large increments in 1974 and 1975 reflect expenditure of previously impounded fiscal year 1973 appropriations

### MENTAL HEALTH RESEARCH FUNDING

Mr. CONTE. Dr. Brown, will you provide us information, in chart form, that will help us understand how funds for NIMH research compares over the past 5 years in relation to those for the NIH Institutes and alcohol and drugs? Will you also specifically compare mental health research funds for those years with research funds for the NIH Institute that had the least increase over that same time period?

Dr. BROWN. I will be happy to do that, Mr. Conte.

[The information follows:]

RESEARCH GRANT FUNDING LEVELS, 1971–75—COMPARISON OF NIMH PROGRAMS WITH NIH, NIDA, AND NIAA

[DOLLAR AMOUNTS IN THOUSANDS]

| | 1971 | 1972 | 1973 | 1974 | 1975 | Percent change |
|---|---|---|---|---|---|---|
| OBLIGATIONS | | | | | | |
| ADAMHA: | | | | | | |
| NIMH | $65,240 | $64,568 | $57,802 | $70,166 | $63,503 | −3 |
| NIDA | [1] 6,624 | [1] 17,241 | 20,131 | 27,497 | 31,575 | +377 |
| NIAAA | [1] 5,807 | [1] 7,532 | 6,472 | 12,809 | 10,492 | +81 |
| Total, ADAMHA | 77,671 | 89,341 | 84,405 | 110,472 | 105,570 | +36 |
| NIH Institutes: | | | | | | |
| Cancer | 233,160 | 378,794 | 492,205 | 527,486 | 691,666 | +197 |
| Heart/lung | 194,925 | 232,627 | 300,000 | 289,550 | 324,130 | +66 |
| Dental | 35,440 | 43,388 | 46,991 | 43,959 | 49,864 | +41 |
| Arthritis, metabolics and digestive | 137,986 | 153,337 | 167,316 | 153,561 | 173,121 | +25 |
| Neurological and stroke | 103,502 | 116,731 | 130,672 | 121,358 | 142,498 | +38 |
| Allergy | 96,412 | 103,518 | 107,647 | 111,063 | 119,369 | +24 |
| Eye | 30,032 | 37,132 | 38,562 | 41,177 | 44,133 | +47 |
| Child health and human development | 94,760 | 116,427 | 130,429 | 125,455 | 141,966 | +50 |
| Environmental health | 20,067 | 25,945 | 30,412 | 28,397 | 34,937 | +74 |
| General medical science | 166,072 | 173,474 | 183,171 | 168,329 | 187,400 | +13 |
| Total, selected NIH | 1,112,356 | 1,381,373 | 1,627,405 | 1,610,335 | 1,909,084 | +72 |

[1] Obligations for alcohol and drug abuse research were subsumed in the NIMH budget, prior to the establishment of the Alcohol, Drug Abuse, and Mental Health Administration in September 1973. Fiscal year 1971 and 1972 amounts for drug and alcohol programs represent estimates.

Mr. CONTE. Will you comprise the purchasing power of the NIMH research budget 5 years ago with that fiscal year 1977?

Dr. BROWN. Five years ago, in 1971, the research grants budget for mental health, excluding drugs and alcohol, was $65,240,000. The 1977 President's budget requests $52,178,000 for this purpose. There has been a 26-percent inflation between 1971 and 1975, or an average of 6.5 percent a year. If we extend this annual average into 1977, the $52,178,000 will buy us $34,959,000 worth of grants, in terms of 1971 dollars. The combination of the budget decrease and inflation therefore gives us a decrease of 33 percent.

Mr. CONTE. Dr. Brown, what was the request for research in your forward plan? What were the major things you planned to emphasize in your research programs?

Dr. BROWN. The NIMH forward plan request for research totaled $128,700,000. Within this total, we had planned $21,100,000 for several new initiatives. These initiatives included $10 million for research in the area of health services delivery; $2,500,000 for the establishment of three clinical research centers; $2 million for the study of depression; $1,500,000 for basic psychological and developmental studies; $1,100,000 for minority mental health research; $1 million for studies of schizophrenia; and $800,000 for initial establishment of a laboratory devoted to the study of mental health problems of the aged. The remaining $2,200,000 was to be applied to new thrusts in the fields of female crime, rape, metropolitan mental health problems, and childhood behavior disorders. The remainder of the $128,700,000 request, or $107,600,000, was to be applied to the strengthening of existing programs, keeping up with inflation, and meeting continuation costs. Included in the $128,700,000 total were $92,800,000 for grants; $4,500,000 for the research scientist program; $3,900,000 for the hospital improvement program, $1,500,000 for research contracts; and $26 million for operation of the intramural research program and

payments to the National Institutes of Health for services rendered in connection with our research programs.

Mr. CONTE. The budget request proposes a $12.9 million decrease for mental health research. What rationale is there for such a reduction and what program areas will be hurt most?

Dr. BROWN. We would not justify the decrease on programmatic or professional grounds, Mr. Conte. Rather the reduction is the result of apparent economic necessity. There are many areas where efforts could be expanded in fiscal year 1977. In the psychopharmacology research area, for example, there are critical studies of immediate public health impact that could be started. A multihospital study planned for the last 2 years to test a combination of drugs which could reduce the relapse rate for depression could be started which could provide patients with a potentially beneficial treatment. Critical kinds of research on schizophrenia and the major affective disorders could be explored. We would like to initiate long-term followup studies aimed at unraveling the course of the disorder, the long-term effects of various treatments, and/or the impact of preventive measures. Funds could also be used to stimulate research in other relevant areas, which as mental disorders are not as severe as the psychoses, but affect and incapacitate far more people: psychoneuroses, psychosomatic disorders, psychosocial illnesses, and childhood psychopathology. We would be able to expand research related to child mental health in such areas as classification and etiology of childhood and adolescent mental disorders; research into the early development of infants and young children which could provide needed information for prevention of emotional disturbance; research on the behavioral effects of television on young children and adolescents; research on the early detection of dyslexia. There are 4 million children with this problem which can lead to severe emotional and personality problems; and school mental health, including the impact of school desegregation and the stress produced by it on children, families, and communities.

### MENTAL HEALTH TRAINING

Mr. CONTE. Dr. Brown, if the President's budget for mental health training programs were to be implemented, how many current trainees would not be able to complete their training? How many faculty members would have to be supported elsewhere?

Dr. BROWN. On the basis of available information, we are unable to predict precisely how many currently supported trainees would not be able to complete their training. Data would first have to be obtained from each grantee institution and an estimate formed as to alternative resources, if any, available to affected students. Overall, however, the total number of clinical trainees supported by NIMH projects would drop from 6,300 to approximately 2,200, for a decrease of 4,100. The number of faculty supported would drop from 1,100 to 400, or by 700 positions.

Mr. CONTE. This is the fourth year of the proposed phaseout of the mental health training program. How have you handled these funding uncertainties in terms of administering the program? What impact does this uncertainty have on the field?

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, over 6,000 students in training, and a minimal Federal contribution of varying degrees toward maintaining viability of the many institutions and agencies throughout the country developing our manpower resource. Since fiscal year 1973, these 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 apprized of prevailing national policies on its receipt. Unquestionably, the annual uncertainty over the status of these major Federal training programs, now running into its fifth year, has had a serious and detrimental impact on our ability to administer the programs in the most effective way; and on the ability of the field to understand and to be responsive to Federal priorities and needs, as the programs have been eventually restored through congressional action.

Despite these factors, we have attempted, through contingency planning and through close collaboration with the training field, to assure that the funds we do eventually expend represent the most effective and judicious use of Federal resources. This has often required belated but heroic efforts on the part of Federal staff and a high degree of understanding and cooperation from training institutions. Under these very trying circumstances, we feel we have been remarkably successful in maintaining the viability and effectiveness of our manpower programs in a responsible manner consistent with previous standards of professionally sound and meritorious review.

Mr. CONTE. How do you justify phasing out NIMH clinical training programs in view of recent court cases and hospital accreditation losses based, in part, on inadequate staff/patient ratios?

Dr. BROWN. You are, of course, correct that some State hospitals are faced with a loss of accreditation of their programs due to inadequate staff/patient ratios. This problem is largely due to the inability or unwillingness of State legislatures to appropriate adequate funds for these hospitals. However, on a national basis, what we are more concerned about is the likelihood that there will be inadequate mental health manpower to meet future demands for community mental health services. In addition to the existing demands, there are increasing needs due to the deinstitutionalization of patients in State hospitals. Preliminary data we have collected to be used in a report required by Congress under Public Law 94–63 indicate that over 400 of the Community Mental Health Center catchment areas that have not yet been reached by the federally funded community mental health center program have only one or none of the 5 essential services of a minimally adequate community mental health service program. As the needed programs are developed in these communities, there will be increased demand for mental health manpower. If the NIMH effort is to be phased out, States and localities will have to pick up this additional burden. We must hope that they will have the will and the capacity to do so.

ALCOHOLISM RESEARCH

Mr. PATTEN. I have noticed that research has consistently been a very small part of your overall budget. Does this mean that alcohol research is not needed or is not a priority activity within your Institute?

Dr. NOBLE. Mr. Patten, I consider research to be the Institute's highest priority. The degree of success in alcoholism prevention and treatment programs is a direct result of how well the problem is understood from a medical, psychological, and social standpoint. Alcoholism research is a relatively new field in the health sciences, and I feel that we should establish closer relationships with those who have demonstrated research excellence in related health fields, both intramurally and extramurally, so that our own research can benefit from the knowledge which they have acquired.

There are a wide range, of critical areas of alcoholism research which need to be explored, and increased knowledge about them can have a significant impact on the alcoholism epidemic in our country. For example, preliminary findings suggest that alcohol abuse among pregnant women can cause physical deformities in their offspring, including heart defects, facial and limb defects, and overall growth deficiency, as well as lower intelligence levels. There are varying degrees of progress in our understanding of the relationship of alcohol use to brain, heart, and liver functioning, and there is a need to follow up on preliminary findings which indicate a possible relationship of excessive alcohol use to certain forms of cancer. More research is needed which will lead to the development of drugs which can block the damaging effects of alcohol on vital organs, and there are many other areas of equal promise for improved methods of treatment for alcohol afflicted people. A particularly challenging aspect of alcoholism research is in finding ways to bring about attitudinal changes in our young people, for alcoholism is a problem which continues to afflict enormous numbers of people who have not yet reached the prime of life.

These are some of the questions that need to be answered if we are to gain a broad base of knowledge which will increase our ability to combat the alcoholism problem. Therefore, Mr. Patten, I not only see the need for research, but I consider research to be fundamental to the success of the Federal alcoholism effort.

Mr. PATTEN. In the Senate, $6 million for National Alcohol Research Centers has been recommended in the renewal legislation. In your professional opinion and drawing on your experience as a researcher and a physician, do you believe that there is a need for a coordinated multidisciplinary approach to alcohol problems conducted by National Alcoholism Research Centers?

Dr. NOBLE. Yes, Mr. Patten, my professional opinion is that such a development is vital, given an economic climate which would be conducive to increased Federal spending in 1977. The national influence which has stimulated community action in the prevention and treatment areas can have a similar effect in the research sphere, and I believe this expansion is needed in order to adequately address the many critical issues such as those I mentioned previously, and to attract an increased number of highly skilled researchers for career work in the field of alcoholism. The National Research Centers would expedite the visibility required to stimulate a broad base of alcoholism

research in the country and would provide coordination and knowledge sharing among biomedical, behavioral, social and other related disciplines, which would strengthen the overall alcoholism research program.

Mr. PATTEN. The Institute's research is conducted on both an extramural and intramural basis, and I understand that your intramural program is located at St. Elizabeths. Is this facility an appropriate location for the conduct of alcoholism research?

Dr. NOBLE. The location of the alcohol research laboratory at St. Elizabeths Hospital, being isolated from the mainstream of the Federal health research community, has hampered the development of a comprehensive alcohol research effort. The laboratory would be more appropriately located in a setting which would provide for interaction between and collaboration with researchers in the related health fields. Such a setting would facilitate the development of alcohol research and contribute to its acceptance as an integral part of the national health research program. A relocation of the laboratory to a location providing a more desirable research environment would enable the Institute to attract a greater number of qualified scientists to the field of alcohol research, and also provide a rich atmosphere for the training of promising new investigators.

The present facilities of the laboratory are inadequate, allowing for only limited basic research. More adequate facilities are needed in order to facilitate ongoing research and allow expansion into a multidisciplinary program dealing with the many and complex factors of alcoholism.

Relocation of the laboratory will be necessary before a clinical program can be established. Such a program is necessary to the development of improved diagnosis and treatment of alcoholism and related diseases and it would serve as a vital link between the research program and the training and treatment programs of the Institute.

Mr. PATTEN. In terms of resources, how does your research program compare with your sister institute involved with drug abuse and mental health?

Dr. NOBLE. The 1976 appropriation for the National Institute of Mental Health includes $95,908,000 for research which is 22 percent of that Institute's total budget. The corresponding amount for the National Institute on Drug Abuse is $34,000,000 which is 16 percent of that Institute's total budget. The 1976 appropriation for the Alcohol Institute includes $11,504,000 for research which is 8 percent of the total alcohol budget.

In terms of manpower resources, as of January 1976, the NIMH has approximately 450 positions allocated to research, the NIDA had approximately 150 as compared to 32 positions allocated to alcohol research within NIAAA.

### ALCOHOLISM INTRAMURAL RESEARCH

Mr. PATTEN. What are the goals and objectives of your intramural research programs? Also, I would like to know if you could cite any specific examples of scientific findings resulting from your research.

Dr. NOBLE. Until the present fiscal year, the alcoholism intramural

research program consisted of 10 positions and approximately a half million dollars. With the small amount of resources previously allocated to this program, a broad base of research could not be established, but the studies which have been conducted have increased our understanding of the biochemical nature of the addictive process and have helped in identifying important mechanisms associated with the metabolism of alcohol. In fiscal year 1976, priority has been given to the development of the intramural program to serve as the focal point within the Government for alcoholism research, and we are in the process now of recruiting 16 new professional, scientific, and supportive staff members for the program. The underlying purpose of this development is to create a multidisciplinary center of excellence at the Federal level to strengthen the overall effort in alcoholism research, and to provide a rich research environment for the training of promising investigators in the field of alcoholism.

ALCOHOLISM TREATMENT AND RESEARCH

Mr. PATTEN. NIAAA has been conducting community treatment programs for the last 5 years. How do you feel that the research has benefited from the establishment of these programs?

Dr. NOBLE. In the past 5 years, the Institute has stimulated widespread awareness which has led to the development of many treatment programs at the State and community level. This sense of awareness has attracted a growing number of people to work in the field of alcoholism. In this regard, the alcoholism research effort has benefited from the treatment program.

There has also been another type of benefit. It is generally understood that the degree of success in treating a health problem depends upon the strength of its research. However, it is also true that research gains from the experience of those conducting treatment. Client outcome data reported by NIAAA treatment program has enabled us to predict the effectiveness of various modes of treatment of alcoholic patients which will influence future research. This experience has also pointed up the need for research on improved treatment efforts for individuals who have longer histories of heavy drinking.

Mr. FLOOD. Thank you, gentlemen.

Mr. ISBISTER. Thank you, Mr. Chairman.

Mr. FLOOD. We will reconvene at 2 o'clock.

# JUSTIFICATION OF THE BUDGET ESTIMATES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse and Mental Health


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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, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, the Narcotic Addict Rehabilitation Act of 1966, and *the Drug Abuse Office and Treatment Act of 1972,*[1/] [$653,627,000] *$623,331,000.* (Additional authorizing legislation to be proposed for $263,200,000.)

[For construction, alterations, extension and equipment of buildings and facilities on the grounds of Saint Elizabeth's Hospital $5,400,000 to remain available until expended.]

[For an additional amount for "Alcohol, drug abuse, and mental health" for carrying out, to the extent not otherwise provided, parts A, B, and D of the Community Mental Health Centers Act and section 603 of Public Law 94-63, $56,500,000.] (Supplemental Appropriation Act, 1976.)

1/ This Act was not included in the Conference Bill for 1976 because it had expired. It is now cited to reflect proposed extension.

Department of Health, Education, and Welfare

Alcohol, Drug Abuse, and Mental Health Administration

Amounts Available for Obligation

| | 1976 Appropriation | 1977 Estimate |
|---|---|---|
| Appropriation | $579,554,000 | $623,331,000 |
| Request Pending | +177,348,000 | --- |
| Proposed Amendment for Buildings and Facilities | +5,200,000 | --- |
| Enacted Supplemental Appropriation | +56,500,000 | --- |
| Subtotal, Appropriation | 818,602,000 | 623,331,000 |
| Comparative transfer to: | | |
| Health Services Administration, Indian Health Service for Indian Alcohol programs | -12,000,000 | --- |
| Comparative transfer from: | | |
| Building and Facilities | +5,400,000 | --- |
| Subtotal, budget authority | 812,002,000 | 623,331,000 |
| Unobligated balance, start of period | +17,208,000 | --- |
| Total, obligations | 829,210,000 | 623,331,000 |

Summary of Changes and Explanation of Changes

| | |
|---|---|
| 1976 Estimated obligations | $829,210,000 |
| 1977 Estimated obligations | 623,331,000 |
| Net change | -205,879,000 |

| | 1976 Base Pos. | 1976 Base Amount | Change from Base Pos. | Change from Base Amount |
|---|---|---|---|---|
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Annualization of 1976 position increase | --- | $1,815,000 | --- | +$1,815,000 |
| 2. Full year cost of October 1975 pay increase | --- | --- | --- | +2,192,000 |
| 3. Within grade increases | --- | --- | --- | +891,000 |
| 4. Increased payment to GSA for rental charges | --- | 1,532,000 | --- | +1,018,000 |
| 5. Increased payment to Office of Federal Employees Compensation | --- | 68,000 | --- | +29,000 |
| 6. Increased payment to Health, Service and Supply Fund | --- | 3,152,000 | --- | +254,000 |
| 7. Increased payment to DHEW Working Capital Fund | --- | 809,000 | --- | +48,000 |
| 8. Increased payment for postage charges | --- | 1,607,000 | --- | +397,000 |
| 9. Increased payment to NIH Management Fund | --- | 7,649,000 | --- | +1,766,000 |
| Subtotal | --- | --- | --- | +8,410,000 |
| B. Program: | | | | |
| 1. Drug Abuse: | | | | |
| a. Community programs: Project grants and contracts - primarily to support 7,000 new treatment slots and demonstration grants related to the use of amphetamines and barbiturates | --- | 139,051,000 | --- | +20,949,000 |
| b. Management and Information - reflects net program increase of $255,000 related to information systems | 295 | 14,121,000 | -43 | +255,000 |
| Subtotal | --- | --- | -43 | +21,204,000 |
| Total Increases | --- | --- | -43 | +29,614,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Decreases: | | | | |
| A. Built-in: | | | | |
| 1. One less day of pay..... | --- | --- | --- | -155,000 |
| B. Program: | | | | |
| 1. General Mental Health: | | | | |
| a. Research - reflects a reduction of $15,110,000 for newly legislated rape program and other extramural research efforts and a reduction of $225,000 related to reduction of 15 positions from the Intramural Research effort..... | 373 | 95,908,000 | -15 | -15,335,000 |
| b. Training - reflects phase out of all NIMH training programs except postdoctoral fellowship programs..... | --- | 85,100,000 | --- | -55,100,000 |
| c. Community Programs: | | | | |
| 1) Construction - reflects phase out of construction programs..... | --- | 14,250,000 | --- | -14,250,000 |
| 2) Staffing - reflects declining continuation costs for all programs initiated under the old CMHC legislation..... | --- | 135,363,000 | --- | -24,837,000 |
| 3) Children's Services - reflects declining continuation costs of all programs initiated under the old CMHC legislation | --- | 26,844,000 | --- | -6,570,000 |
| 4) Operation of CMHC's - no funds are requested in 1977 to continue newly legislated CMHC programs | --- | 53,500,000 | --- | -53,500,000 |
| d. Management and Information - reflects a reduction of $2,370,000 related to an employment reduction of 158 positions in 1977 as well as a decrease in operating funds of $1,190,000..... | 530 | 22,229,000 | -158 | -3,560,000 |
| 2. Drug Abuse: | | | | |
| a. Research - reflects reduction in research efforts.. | --- | 34,000,000 | --- | -110,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| b. Training - reflects phase out of drug abuse training grant and predoctoral fellowship programs and the elimination of Regional Training Centers..... | --- | 10,000,000 | --- | -6,000,000 |
| 3. Alcoholism: | | | | |
| a. Research - reflects reduction in Alcohol research efforts..... | --- | 11,504,000 | --- | -1,795,000 |
| b. Training - reflects phase out of Alcohol training programs except the post-doctoral fellowship programs | --- | 7,458,000 | --- | -5,458,000 |
| c. Community Programs: | | | | |
| 1) Project grants and contracts - reflects reduction in continuation costs for existing programs..... | --- | 56,408,000 | --- | -22,957,000 |
| 2) Grants to States - this represents a reduction in grants to states for Alcohol programs..... | --- | 55,500,000 | --- | -9,900,000 |
| d. Management and Information - reflects a decrease of $1,335,000 related to an employment reduction of 89 positions and a reduction in operations funds of $913,000..... | 169 | 8,053,000 | -89 | -2,248,000 |
| 4. Buildings and Facilities - all future Buildings and Facilities appropriations for Saint Elizabeth's Hospital will be proposed as separate legislation..... | --- | 13,558,000 | --- | -13,558,000 |
| 5. Program Direction - reflects a decrease of $160,000 related to an employment reduction of 16 positions..... | 354 | 11,363,000 | -16 | -160,000 |
| Subtotal..... | --- | --- | -321 | -235,338,000 |
| Total Decreases..... | --- | --- | -321 | -235,493,000 |
| Net Change..... | --- | --- | -321 | -205,879,000 |

Obligations by Activity

| | 1976 Revised Pres. Budget | | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Gen. Men. Hlth. | | | | | | | | |
| Research.... | 373 | $82,700,000 | 373 | $95,908,000 | 358 | $83,000,000 | -15 | -$12,908,000 |
| Training.... | --- | 45,100,000 | --- | 85,100,000 | --- | 30,000,000 | --- | -55,100,000 |
| Comm. Prog.: | | | | | | | | |
| Coop. Stat.. | --- | --- | --- | --- | --- | --- | --- | --- |
| Constuction. | --- | 14,250,000 | --- | 14,250,000 | --- | --- | --- | -14,250,000 |
| (B.A.).... | --- | (---) | --- | (---) | --- | (---) | --- | (---) |
| Staffing... | --- | 135,363,000 | --- | 135,363,000 | --- | 110,526,000 | --- | -24,837,000 |
| Child. Svc. | --- | 24,780,000 | --- | 26,844,000 | --- | 20,274,000 | --- | -6,570,000 |
| Op. of CMHC | --- | --- | --- | 53,500,000 | --- | --- | --- | -53,500,000 |
| Subtotal.. | --- | 174,393,000 | --- | 229,957,000 | --- | 130,800,000 | --- | -99,157,000 |
| Mgt. & Info. | 374 | 20,229,000 | 530 | 22,229,000 | 372 | 20,414,000 | -158 | -1,815,000 |
| Subt. GMH.... | 747 | 322,422,000 | 903 | 433,194,000 | 730 | 264,214,000 | -173 | -168,980,000 |
| (B.A.).... | --- | (308,172,000) | --- | (418,944,000) | --- | (264,214,000) | --- | (-154,730,000) |
| Drug Abuse | | | | | | | | |
| Research.... | 102 | 31,602,000 | 102 | 34,000,000 | 102 | 34,000,000 | --- | --- |
| Training.... | --- | 3,000,000 | --- | 10,000,000 | --- | 4,000,000 | --- | -6,000,000 |
| Comm. Prog.: | | | | | | | | |
| Proj. Grants & Contr... | --- | 137,962,000 | --- | 139,051,000 | --- | 160,000,000 | --- | +20,949,000 |
| Grants to States.... | --- | 35,000,000 | --- | 35,000,000 | --- | 35,000,000 | --- | --- |
| Subtotal.. | --- | 172,962,000 | --- | 174,051,000 | --- | 195,000,000 | --- | +20,949,000 |
| Mgt. & Info. | 260 | 14,674,000 | 295 | 14,121,000 | 252 | 14,827,000 | -43 | +706,000 |
| Subt. D.A.... | 362 | 222,238,000 | 397 | 232,172,000 | 354 | 247,827,000 | -43 | +15,655,000 |
| Alcoholism | | | | | | | | |
| Research.... | 12 | 9,696,000 | 26 | 11,504,000 | 26 | 10,000,000 | --- | -1,504,000 |
| Training.... | --- | 6,958,000 | --- | 7,458,000 | --- | 2,000,000 | --- | -5,458,000 |
| Comm. Prog.: | | | | | | | | |
| Proj. Grants & Contr... | --- | 45,451,000 | --- | 56,408,000 | --- | 33,451,000 | --- | -22,957,000 |
| Grants to States.... | --- | 45,600,000 | --- | 55,500,000 | --- | 45,600,000 | --- | -9,900,000 |
| Subtotal.. | --- | 91,051,000 | --- | 111,908,000 | --- | 79,051,000 | --- | -32,857,000 |
| Mgt. & Info. | 95 | 7,053,000 | 169 | 8,053,000 | 80 | 7,011,000 | -89 | -1,042,000 |
| Subt. Alcoh.. | 107 | 114,758,000 | 195 | 138,923,000 | 106 | 98,062,000 | -89 | -40,861,000 |
| Buildings & Facilities.. | --- | 13,558,000 | --- | 13,558,000 | --- | --- | --- | -13,558,000 |
| (B.A.).... | --- | (10,600,000) | --- | (10,600,000) | --- | --- | --- | (-10,600,000) |
| Prog. Direct. | | | | | | | | |
| S.L.U.C..... | --- | 1,532,000 | --- | 1,532,000 | --- | 2,550,000 | --- | +1,018,000 |
| Other Expen. | 343 | 9,831,000 | 354 | 9,831,000 | 338 | 10,678,000 | -16 | +847,000 |
| Subtotal P.D. | 343 | 11,363,000 | 354 | 11,363,000 | 338 | 13,228,000 | -16 | +1,865,000 |
| Total ADAMHA. | 1,559 | 684,339,000 | 1,849 | 829,210,000 | 1,528 | 623,331,000 | -321 | -205,879,000 |
| (B.A.).... | --- | (667,131,000) | --- | (812,002,000) | --- | (623,331,000) | --- | (-188,671,000) |

Obligations by Object

| | 1976 Appropriation | 1977 Estimate | Increase/ Decrease |
|---|---|---|---|
| Total number of permanent positions..... | 1,849 | 1,528 | -321 |
| Full-time equivalent of all other positions.... | 308 | 308 | --- |
| Average number of all employees..... | 1,986 | 1,897 | -89 |
| Personnel compensation: | | | |
| Permanent positions... | 34,633,000 | 33,698,000 | -935,000 |
| Positions other than permanent..... | 3,113,000 | 3,151,000 | +38,000 |
| Other personnel compensation..... | 1,168,000 | 1,151,000 | -17,000 |
| Subtotal, personnel compensation... | 38,914,000 | 38,000,000 | -914,000 |
| Personnel Benefits..... | 4,086,000 | 4,071,000 | -15,000 |
| Travel & transportation of persons..... | 2,512,000 | 2,462,000 | -50,000 |
| Transportation of things | 79,000 | 79,000 | --- |
| Rent, communications & utilities..... | 4,609,000 | 5,954,000 | +1,345,000 |
| Printing & reproduction. | 1,197,000 | 1,165,000 | -32,000 |
| Other services..... | 30,080,000 | 18,998,000 | -11,082,000 |
| Project contracts..... | 71,164,000 | 88,866,000 | +17,702,000 |
| Supplies and materials.. | 2,059,000 | 2,009,000 | -50,000 |
| Equipment..... | 1,528,000 | 1,498,000 | -30,000 |
| Grants, subsidies & contributions..... | 672,982,000 | 460,229,000 | -212,753,000 |
| Total obligations by object..... | 829,210,000 | 623,331,000 | -205,879,000 |

Significant Items in House and Senate
Appropriations Committee Reports

| Item | Action taken or to be taken |
|---|---|
| 1976 Senate Report | |
| Mental Health | |
| 1. The Committee urges the Institute to develop a program aimed at improving the mental health of our Native Americans. (page 69-70 of the Report) | 1. The NIMH has funded a National Mental Health Research and Development Center for American Indians and Alaskan Natives, with the objective of the Center being determined by the Native Americans themselves. Other programs include bibliographic research on the American Indian and a training program to develop the skills of Native Americans in the treatment of their own racial group. |
| Alcohol Community Programs | |
| 2. The committee concurs with the House and amplifies the position that the NIAAA should act solely in a consultive role without in any way becoming involved in the collective bargaining process regard- initiatives to establish employee alcoholism programs. (page 71-72 of the Report) | 2. The NIAAA is restricting its role to that of acting only as a consultive agent for labor and management regarding employee alcoholism programs and is not becoming involved in the collective bargaining process. |
| Alcohol and Drug Abuse Community Programs | |
| 3. The Committee encourages a substantive initiative in alcohol and drug abuse education programs. (page 72 of the Report) | 3. The NIAAA and the NIDA are engaging in efforts to further the state of the art and dissemination of information relating to alcohol and drug abuse education. These efforts will continue in both areas in FY 1977, although at a reduced level in the NIAAA. |
| General | |
| 4. The Committee requests that the fiscal year 1977 budget allocate its positions and Direct Operations support among the appropriate research, training and service activities. It allows the Agency to use its own discretion in dealing with the allocation of individuals and subsidary budgets which may administer a combination of these activities, but it is the intent that Management and Information activities be confined to true overhead expenses. (page 25 of the Report) | Because of overlapping functions, it is impossible to allocate positions to each activity within an Institute. The distribution allocates intramural research positions to the Research line item, all other Institute personnel are allocated to the Management and Information line item. Program Direction reflects the positions and overhead expenses of the Agency as well as positions and costs assigned to the Regional Offices. |

## Authorizing Legislation

| Legislation | Authorized | 1977 Budget Request |
|---|---|---|
| General Mental Health | | |
| Research: | | |
| General | | |
| PHS Act - Sec. 301 | Indefinite | $83,000,000 |
| Rape Prevention and Control | | |
| CMHC Act, Sec. 231(d) | $10,000,000 | --- |
| Training: | | |
| Clinical Training | | |
| PHS Act - Sec. 303 | Indefinite | 24,490,000 |
| Research Training | | |
| PHS Act - Sec. 472 | 1/ | 5,510,000 |
| Community Programs: | | |
| Community Mental Health Centers Act | | |
| Staffing - Section 203(e)(1) | Sums necessary | 110,526,000 |
| Childrens Services - Sec. 203(e)(1) | Sums necessary | 20,274,000 |
| Planning - Sec. 202(d) | 3,750,000 | --- |
| Initial Operation - Sec. 203(d)(1) | 55,000,000 | --- |
| Consultation and Education - Sec. 204(c) | 15,000,000 | --- |
| Conversion Grants - Sec. 205(c) | 20,000,000 | --- |
| Financial Distress - Sec. 213 | 15,000,000 | --- |
| Facilities Assistance - Sec. 228 | 5,000,000 | --- |
| Management and Information: | | |
| PHS Act - Sec. 301 | Indefinite | 20,414,000 |
| Drug Abuse | | |
| Research: | | |
| PHS Act - Sec. 301 | Indefinite | 34,000,000 |
| Training: | | |
| Clinical Training: | | |
| Contracts: | | |
| PHS Act - Sec. 301 | Indefinite | 2,400,000 |
| Grants: | | |
| PHS Act - Sec. 303 | Indefinite | 1,100,000 |
| Research Training: | | |
| PHS Act - Sec. 472 | 1/ | 500,000 |
| Community Programs: | | |
| Staffing: CMHC Act - Sec. 203 | Sums necessary | 13,013,000 |
| NARA Contracts: | | |
| NARA Act - Sec. 607 | Sums necessary | 1,102,000 |
| Neuro-psychiatric Contract: | | |
| PHS Act - Sec. 301 | Indefinite | 600,000 |
| Special Project Grants and Contracts: | | |
| DAOT Act - Sec. 410 | 1/ | 145,285,000 |
| Grants to States: | | |
| DAOT Act - Sec. 409 | 1/ | 35,000,000 |
| Management and Information: | | |
| PHS Act - Sec. 301 | Indefinite | 14,827,000 |

| Legislation | Authorized | 1977 Budget Request |
|---|---|---|
| Alcohol | | |
| Research: | | |
| PHS Act - Sec. 301 | Indefinite | $10,000,000 |
| Training: | | |
| Clinical Training | | |
| PHS Act - Sec. 303 | Indefinite | 1,600,000 |
| Research Training | | |
| PHS Act - Sec. 472 | 1/ | 400,000 |
| Community Programs: | | |
| Staffing - CMHC Act Sec. 203 | Sums necessary | --- |
| Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment and Rehabilitation Act: | | |
| Uniform Act Implementation - Sec. 304 | $13,000,000 | 2,546,000 |
| Grants and Contracts for the Prevention and Treatment of Alcohol Abuse and Alcoholism - Sec. 311 | 2/ | 30,905,000 |
| Grants to States - Sec. 301 | 2/ | 45,600,000 |
| Management and Information: | | |
| PHS Act - Sec. 301 | Indefinite | 7,011,000 |
| Program Direction | | |
| Standard Level User Charges (SLUC) | | |
| PHS Act, Sec. 301 | Indefinite | 2,550,000 |
| Other Expenses | | |
| PHS Act, Sec. 301 | Indefinite | 10,678,000 |
| Total..... | | 623,331,000 |

1/ Legislation expires June 30, 1975, authorizing legislation to be submitted.
2/ Legislation expires June 30, 1976, authorizing legislation to be submitted.

Alcohol, Drug Abuse and Mental Health

Appropriations History

| Year | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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 |
| 1975 | 692,190,000 | 761,601,000 | 811,114,000 | 795,636,000 |
| 1976 | 464,279,000 | 545,654,000 | 589,998,000 | 567,554,000 1/ |
| Amendment | 5,200,000 | --- | --- | --- |
| Request Pending | 177,348,000 | --- | --- | --- |
| Supplemental | --- | 50,500,000 | 64,500,000 | 56,500,000 |
| 1977 | 623,331,000 2/ | | | |

1/ Conference action
2/ Includes $263,200,000 for which authorizing legislation is to be proposed.

Justification

Alcohol, Drug Abuse, and Mental Health Administration

| | 1976 Revised Pres. Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| General Mental Health..... | $322,422,000 | $433,194,000 | $264,214,000 | -$168,980,000 |
| Drug Abuse..... | 222,238,000 | 232,172,000 | 247,827,000 | +15,655,000 |
| Alcoholism..... | 114,758,000 | 138,923,000 | 98,062,000 | -40,861,000 |
| Buildings and Facilities..... | 13,558,000 | 13,558,000 | --- | -13,558,000 |
| Program Direction. | 11,363,000 | 11,363,000 | 13,228,000 | +1,865,000 |
| Total..... | 684,339,000 | 829,210,000 | 623,331,000 | -205,879,000 |

General Statement

The basic mission of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) is to develop knowledge, manpower, and treatment services to assist the nation in understanding and addressing the continuing phenomena of mental illness, the abuse of drugs, and the misuse of alcohol.

The Agency's FY 1977 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 ADAMHA supports our basic philosophy that research activities should be and are the highest priority of the Agency. In terms of both economics and ultimate results, a strong research program is the best investment that can be made in promoting our primary goals. In Mental Health and Alcohol community programs, the budget proposes folding these activities into a new federal consolidated state health bloc grant program. This approach will provide the states and local communities with greater flexiblity in adapting health care funds to their specific needs. In recognition of our increasingly serious national drug abuse problem and the major role which the federal government plays in addressing this problem, the budget not only excludes this treatment program from the proposed bloc grant program, but also proposes an increase in the number of treatment slots supported by the Agency from the FY 1976 level of 95,000 to 102,000 in FY 1977. In training, the budget proposes the phase out of clinical and research training grant activities, and predoctoral research training fellowship awards, but allows for continued support of postdoctoral fellowships.

I. General Mental Health

| | 1976 Revised Pres. Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Research... | 373 | $82,700,000 | 373 | $95,908,000 | 358 | $83,000,000 | -15 | -$12,908,00 |
| Training... | --- | 45,100,000 | --- | 85,100,000 | --- | 30,000,000 | --- | -55,100,000 |
| Comm. Prog. | --- | 174,393,000 | --- | 229,957,000 | --- | 130,800,000 | --- | -99,157,000 |
| (B.A.)..... | --- | (160,143,000) | --- | (215,707,000) | --- | (130,800,000) | --- | (-84,907,000) |
| Mgt. & Info | 374 | 20,229,000 | 530 | 22,229,000 | 372 | 20,414,000 | -158 | -1,815,000 |
| Total..... | 747 | 322,422,000 | 903 | 433,194,000 | 730 | 264,214,000 | -173 | -168,980,000 |
| (B.A.)..... | --- | (308,172,000) | --- | (418,944,000) | --- | (264,214,000) | --- | (-154,730,000) |

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 disorders. 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 disorders; (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 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 mental disorders to the public and to the scientific community.

A. Research:

Activity Summary

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Research grants... | --- | $63,848,000 | --- | $52,178,000 | --- | -$11,670,000 |
| Research Scientist Development..... | --- | 4,400,000 | --- | 3,860,000 | --- | -540,000 |
| Hospital Improvement Projects.... | --- | 5,900,000 | --- | 3,500,000 | --- | -2,400,000 |
| Direct Operations. | 373 | 20,690,000 | 358 | 22,892,000 | -15 | +2,202,000 |
| Contracts..... | --- | 1,070,000 | --- | 570,000 | --- | -500,000 |
| Total..... | 373 | 95,908,000 | 358 | 83,000,000 | -15 | -12,908,000 |

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 tables:

1. Research grants:

Distribution of Research Grants by Type

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Continuations | 558 | $47,220,000 | 451 | $33,986,000 | -107 | -$13,234,000 |
| Competing renewals | 72 | 4,515,000 | 169 | 10,705,000 | +97 | +6,190,000 |
| New projects | 174 | 10,382,000 | 110 | 6,207,000 | -64 | -4,175,000 |
| Small grants | 145 | 874,000 | 145 | 874,000 | --- | --- |
| Supplementals | (39) | 857,000 | (22) | 406,000 | (-17) | -451,000 |
| Total | 949 | 63,848,000 | 875 | 52,178,000 | -74 | -11,670,000 |

Research Grants Program Distribution

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| Continuations: | No. | Amount | No. | Amount | No. | Amount |
| Behavioral science | 195 | $10,583,000 | 165 | $8,215,000 | -30 | -$2,368,000 |
| Clincial research | 82 | 8,803,000 | 63 | 6,829,000 | -19 | -1,974,000 |
| Applied research | 55 | 3,597,000 | 39 | 2,396,000 | -16 | -1,201,000 |
| Psychopharmacology | 113 | 9,437,000 | 83 | 6,497,000 | -30 | -2,940,000 |
| Epidemiology | 12 | 1,265,000 | 14 | 836,000 | +2 | -429,000 |
| Services development | 45 | 6,361,000 | 26 | 3,237,000 | -19 | -3,124,000 |
| Crime & delinquency | 22 | 2,684,000 | 20 | 2,423,000 | -2 | -261,000 |
| Metropolitan problems | 14 | 1,247,000 | 20 | 981,000 | +6 | -266,000 |
| Minority M.H. | 18 | 3,043,000 | 21 | 2,572,000 | +3 | -471,000 |
| Rape | 2 | 200,000 | -- | --- | -2 | -200,000 |
| Subtotal, Continuations | 558 | 47,220,000 | 451 | 33,986,000 | -107 | -13,234,000 |
| Competing/New: | | | | | | |
| Behavioral science | 122 | 3,776,000 | 122 | 3,911,000 | --- | +135,000 |
| Clinical research | 62 | 2,145,000 | 73 | 3,065,000 | +11 | +920,000 |
| Applied research | 41 | 1,043,000 | 53 | 1,787,000 | +12 | +744,000 |
| Psychopharmacology | 72 | 2,524,000 | 69 | 2,720,000 | -3 | +196,000 |
| Epidemiology | 17 | 634,000 | 25 | 811,000 | +8 | +177,000 |
| Services development | 8 | 909,000 | 17 | 2,082,000 | +9 | +1,173,000 |
| Crime & delinquency | 9 | 802,000 | 15 | 1,326,000 | +6 | +524,000 |
| Metropolitan problems | 12 | 501,000 | 23 | 754,000 | +11 | +253,000 |
| Minority M.H. | 11 | 709,000 | 20 | 1,199,000 | +9 | +490,000 |
| Rape | 25 | 2,500,000 | -- | --- | -25 | -2,500,000 |
| Scientific evaluation | 12 | 228,000 | 7 | 131,000 | -5 | -97,000 |
| Supplementals | (39) | 857,000 | (22) | 406,000 | (-17) | -451,000 |
| Subtotal, New/ Competing | 391 | 16,628,000 | 424 | 18,192,000 | +33 | +1,564,000 |
| Total, Grants | 949 | 63,848,000 | 875 | 52,178,000 | -74 | -11,670,000 |

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.

Impact of 1977 budget:

a. Behavioral sciences: The 1977 request will support a total of 122 new and competing awards. The 1977 program will concentrate upon continued research on early detection of language and learning disabilities, and prevention of secondary emotional and interpersonal problems. NIMH will also support studies of psychosocial and biomedical factors underlying normal and deviant behavior, and processes in early adolescence. There will be continued research on early emotional and personality development, and factors relating to maladaptive behaviors. Further study of brain and behavioral relationships will be undertaken, as these relate to normal functioning and to both psychiatric and neurological disorders. The Institute will also support research into the mental health effects of changing sex roles, alternate family styles, and rapid cultural and social change.

b. Clinical Research: A total of 73 new and competing projects will be supported in 1977. Focus will be on studies of the psychobiological, clinical, and psychosocial aspects of the major mental disorders. Emphasis will be upon development of new clinical research methods, strategies, and treatments. Examples of new methods to be pursued include development of new standard methods for clinical diagnosis of major psychoses; applications of new biochemical technology; initiation of new methods for video analysis of verbal and expressive behavior for assessing changes in psychological and clinical states; development of computerized methods for studying and profiling levels of metabolites in body fluids; and development of standard computerized methods for analyzing sleep stages. Research strategies will include development of new animal models for studying cause and development of affective disorders; refinements of high-risk strategy in perspective of study of development of psychoses in identifying vulnerable children; and development of a model for studying ethnic variations in expression of psychopathology in a community. Study in the area of new treatments will include early testing of biofeedback methods in modifying range of psychosomatic disorders and psychological disturbances; and successful application of behavior modification therapies to autism, behavior disorders, and phobic neuroses.

c. Applied Research: A total of 53 new and competing projects is expected to be supported in 1977. Special emphasis will be placed on infant development and parental attachment, adolescent behavior, changing family patterns and values, sexuality, and mental health aspects of aging. The Institute will continue to support projects designed to increase understanding of contemporary social problems, and problems related to the mental health of juveniles - especially those problems which are primarily associated with social and environmental conditions.

d. Psychopharmacology: During 1977, the Institute expects to support a total of 69 new and competing projects, relating principally to the following areas: development of more effective utilization of drugs in treatment service settings; program studies of drug side effects; and support of a collaborative study in geriatric psychopharmacology; and support of a collaborative study of community maintenance medication in recurrent affective disorders.

e. Epidemiology: NIMH expects to award 25 new and competing grants in this area during 1977. The primary focus is on strengtening the search for causative factors with particular emphasis on the role of genetic transmission. Special consideration will be given to depression and suicide in relation to life events or environmental stress. To assist these endeavors the development and refinement of self-report questionnaires for use in community case-finding programs will be encouraged. Factors affecting the course and outcome of treatment and adjustment at home, in the community, and at work will be assessed.

f. Services development: A total of 17 new and competing awards will be supported in 1977. Research development will be integrated into a system encompassing a formal assessment of emerging needs; knowledge retrieval; knowledge development through special research projects; and technical assistance relating to diffusion and utilization of knowledge in the services delivery area.

g. Crime & delinquency: The NIMH Center for Studies of Crime and Delinquency will support a total of 15 new and competing research grant awards for 1977. The Center plans to undertake a new research initiative in the area of female crime and delinquency. In addition, support will be continued for studies on individual violent behavior, on commitment and treatment of mentally ill offenders, and on the effectiveness of various types of community-based strategies for providing treatment and service to delinquents outside the criminal justice system. Support will also be continued for research leading to further refinement of a new type of community-based residential group home for delinquents which has been adopted for use in 14 states.

h. Metropolitan problems: The NIMH Center for Studies Metropolitan Problems will support approximately 23 new and competing awards in 1977. The Center will deal with basic issues relating to the ways in which human beings function under stress, and the kind of formal and informal support systems available to them. One program focus will be on economic and work-related crises. The Center will also study mental health implications of urban and ethnic conflict; residential and social segregation by age, marital status, and income; the effects of residential and neighborhood density upon individual functioning in the family life; and evaluation of the community effects of neighborhood mental health facilities.

i. Minority mental health: Approximately 20 new and competing grants will be awarded in the area of minority mental health. The Institute will concentrate on development of new therapeutic methods specifically applicable to minority populations. We plan to study the most effective processes, procedures, and strategies for implementing research findings to improve the services provided to minorities by existing mental health delivery systems. The Institute also plans to study development of the state of the art on psychosocial effects of racism upon minority and non-minority populations.

j. Rape: During 1976, a total of $3,000,000 in the supplemental appropriation implementing Part D of P.L. 94-63 was appropriated for research into the causes and prevention of rape. Of this amount, $2,500,000 will be used for grants and $500,000 will be used for contracts. No funds are requested for continuation of activities initiated with supplemental funds.

k. Issues common to all program areas: Cutting across most of the program areas outlined above are the Institute's continuing studies of schizophrenia, depression, and mental health of children. During 1977, NIMH will continue a strong program of basic psychologic, biomedical and genetic research into the causes of schizophrenia. We will continue with a program of development and evaluation with special attention to studies of adjustment and quality of life among patients in the community, and assessment of contributions, accomplishments, problems and new directions of studies pertaining to children who have an unusually high risk of development of schizophrenia. Work will also be undertaken relating to the study of borderline schizophrenics.

In the area of depression, NIMH plans to intensify collaborative research on psychological and psychosocial-cultural factors which influence the development and course of depression. In addition, tests will be made of new genetic models which portray the transmission of this mental health problem.

Child mental health research will include development of data on emotional states and depressive disorders; research relating to hyperkinetic disorders; study of the mental health dimensions of learning disorders; problems of early adolescence, and exploration of areas requiring support for longitudinal research.

2. Research Scientist Development Program:

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Continuations..... | 104 | $3,297,000 | 105 | $3,329,000 | +1 | +$32,000 |
| Competing renewals.. | 8 | 263,000 | --- | --- | -8 | -263,000 |
| New projects..... | 26 | 817,000 | 17 | 531,000 | -9 | -286,000 |
| Supplementals..... | (4) | 23,000 | --- | --- | (-4) | -23,000 |
| Total..... | 138 | 4,400,000 | 122 | 3,860,000 | -16 | -540,000 |

The purpose of this program is 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. 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.

Impact of 1977 budget:

During 1977, a total of 17 new and competing awards will be supported. Of this total, 10 will represent research scientist development awards, and 7 will relate to the research scientist program.

3. Hospital Improvement Program:

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Continuations..... | 46 | $4,500,000 | 25 | $2,500,000 | -21 | -$2,000,000 |
| Competing renewals.. | 4 | 400,000 | 4 | 400,000 | --- | --- |
| New Projects..... | 10 | 1,000,000 | 6 | 600,000 | -4 | -400,000 |
| Supplementals..... | --- | --- | -- | --- | -- | --- |
| Total..... | 60 | 5,900,000 | 35 | 3,500,000 | -25 | -2,400,000 |

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. Support to and institution may not exceed 10 years and each hospital may not receive more than $100,000 in any one year.

Impact of 1977 budget:

By September 30, 1977 a total of 305 Hospital Improvement grants will have been awarded to 222 state mental hospitals.

4. Direct Operations:

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Direct Operations..... | 373 | $20,690,000 | 358 | $22,892,000 | -15 | +$2,202,000 |

The intramural research program operates through laboratories located on the campus of the National Institutes of Health, and on the grounds of Saint Elizabeths Hospital. Efforts are directed at integrating fundamental knowledge obtained on how nerves and brain function with investigations in human subjects of such diseases as schizophrenia and depression. The primary aim of this program is to relieve suffering from mental illness, through improved diagnostic and treatment methods and additionally, to contribute to basic knowledge which will explain the onset of these disorders, and lead to their prevention.

Impact of 1977 Budget:

The intramural research program will continue its work in several promising areas developed during the past year. Among these are the following:

a. Brain function: In what has been described as a major breakthrough, the intramural research program has developed a new method for studying brain function which offers extraordinary advantages over existing methods. The discovery stems from knowledge that in the brain, as in other bodily tissues, functional activity of any part is paralleled by metabolic activity; and that glucose consumption is a measure of that activity. In the past, it has not been possible to measure glucose consumption directly in localized areas of the brain; however, this new method provides an accurate, indirect measure. With it, scientists can explore any number of mental health problems heretofore not researchable. Paramount among these will be the effects of various drugs on brain function and behavior.

b. Phenylketonuria (PKU): This disease is characterized by inborn errors of metabolism which result in mental retardation. The only known treatment is difficult, expensive, and not always effective. Investigators are currently evaluating the therapeutic effectiveness of administering the metabolic products essential to normal functioning at a point beyond which the PKU enzyme defect occurs. If this method proves successful, it will offer a significant improvement over existing treatment modalities for the prevention of mental retardation in certain PKU victims. The technique should also provide a useful model for intervening in other diseases associated with inborn metabolic errors.

c. Schizophrenia: Studies of chronic schizophrenic patients will continue as a primary focus of the intramural research program. One major finding to be pursued is that certain chemical activity is low in the platelets of schizophrenic patients, and that this deficit seems to be genetically determined. The task that remains is to discover if this finding is related to the cause of the illness, or whether it has some other meaning.

d. Mental Disorders of Childhood: An area of special interest is a preliminary finding that the children of patients who have been admitted to NIMH wards in the last ten years with affective illnesses, show a higher incidence of depressive reactions than of those in the normal population. Work on other childhood behavior disorders, particularly hyperactivity, will be continued.

B. Training:

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Training grants..... | 1,149 | $80,028,000 | 870 | $28,025,000 | -279 | -$52,003,000 |
| Hospital staff development grants..... | 96 | 2,400,000 | 49 | 538,000 | -47 | -1,862,000 |
| Fellowships..... | 224 | 2,672,000 | 178 | 1,437,000 | -46 | -1,235,000 |
| Total..... | 1,469 | 85,100,000 | 1,097 | 30,000,000 | -372 | -55,100,000 |

The purpose of this activity is to train 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.

Impact of 1977 Budget:

Clinical Training: The 1977 budget proposes the phasing-out of clinical training activities. Funds provided for this activity will be utilized to support 802 continuation awards at approximately 45 percent of their normal commitment level.

Research Training: The 1977 budget proposes the phase-out of all research training grants and predoctoral fellowships. All awards will be reduced 55% below their commitment level. The Administration will continue to fully support efforts in the post doctoral area, although no funds are available for new awards.

Workload Data: Information on numbers of awards by type of grant and program is set forth on the following tables.

Analysis of Training Grants by Type

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Clinical Training: | | | | | | |
| Grants: | | | | | | |
| Regular: | | | | | | |
| Continuations... | 944 | $66,084,000 | 745 | $23,737,000 | -199 | -$42,347,000 |
| Competing..... | 13 | 1,033,000 | --- | --- | -13 | -1,033,000 |
| New..... | 8 | 449,000 | 8* | 215,000 | --- | -234,000 |
| Supplemental.... | --- | --- | --- | --- | --- | --- |
| Subtotal..... | 965 | 67,566,000 | 753 | 23,952,000 | -212 | -43,614,000 |
| Hospital Staff Development: | | | | | | |
| Continuation.... | 57 | 1,425,000 | 49 | 538,000 | -8 | -887,000 |
| Competing..... | -- | --- | --- | --- | --- | --- |
| New..... | 39 | 975,000 | --- | --- | -39 | -975,000 |
| Subtotal..... | 96 | 2,400,000 | 49 | 538,000 | -47 | -1,862,000 |
| Total Clinical Training..... | 1,061 | 69,966,000 | 802 | 24,490,000 | -259 | -45,476,000 |
| Research Training: | | | | | | |
| Grants: | | | | | | |
| Continuations.... | 169 | 11,943,000 | 122 | 3,988,000 | -47 | -7,955,000 |
| Competing..... | --- | --- | --- | --- | --- | --- |
| New..... | 8 | 519,000 | 3* | 85,000 | -5 | -434,000 |
| Supplementals.... | --- | --- | --- | --- | --- | --- |
| Subtotal..... | 177 | 12,462,000 | 125 | 4,073,000 | -52 | -8,389,000 |
| Fellowships: | | | | | | |
| Predoctoral: | | | | | | |
| Continuation.... | 57 | 402,000 | 95 | 252,000 | +38 | -150,000 |
| New/competing... | 35 | 243,000 | --- | --- | -35 | -243,000 |
| Subtotal..... | 92 | 645,000 | 95 | 252,000 | +3 | -393,000 |
| Postdoctoral: | | | | | | |
| Continuation.... | 74 | 1,098,000 | 83 | 1,185,000 | +9 | +87,000 |
| New/competing... | 58 | 929,000 | --- | --- | -58 | -929,000 |
| Subtotal..... | 132 | 2,027,000 | 83 | 1,185,000 | -49 | -842,000 |
| Total fellowship.. | 224 | 2,672,000 | 178 | 1,437,000 | -46 | -1,235,000 |
| Total Research Training..... | 401 | 15,134,000 | 303 | 5,510,000 | -98 | -9,624,000 |
| Total training.... | 1,462 | 85,100,000 | 1,105 | 30,000,000 | -357 | -55,100,000 |

* Scientific Evaluation awards only. These are awarded to review committees who evaluate grant applications.

Analysis of Regular Grants by Program Distribution - Training

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Clinical training: | | | | | | |
| Continuations: | | | | | | |
| Psychiatry..... | 412 | $27,033,000 | 365 | $10,607,000 | -47 | -$16,426,000 |
| Nursing..... | 95 | 8,274,000 | 53 | 2,563,000 | -42 | -5,711,000 |
| Social Work..... | 126 | 11,242,000 | 100 | 4,148,000 | -26 | -7,094,000 |
| Psychology..... | 160 | 8,328,000 | 145 | 3,542,000 | -15 | -4,786,000 |
| Continuing Ed... | 30 | 1,804,000 | 13 | 486,000 | -17 | -1,318,000 |
| Exper. & Spec... | 121 | 9,403,000 | 69 | 2,391,000 | -52 | -7,012,000 |
| Subtotal..... | 944 | 66,084,000 | 745 | 23,737,000 | -199 | -42,347,000 |
| Competing/New: | | | | | | |
| Psychiatry..... | 6 | 453,000 | --- | --- | -6 | -453,000 |
| Nursing..... | 1 | 75,000 | --- | --- | -1 | -75,000 |
| Social Work..... | 3 | 238,000 | --- | --- | -3 | -238,000 |
| Psychology..... | 3 | 191,000 | --- | --- | -3 | -191,000 |
| Continuing Ed... | 1 | 60,000 | --- | --- | -1 | -60,000 |
| Exper. & Spec... | 7 | 465,000 | --- | --- | -7 | -465,000 |
| Scientific Eval. | -- | --- | 8 | 215,000 | +8 | +215,000 |
| Subtotal..... | 21 | 1,482,000 | 8 | 215,000 | -13 | -1,267,000 |
| Total clinical training..... | 965 | 67,566,000 | 753 | 23,952,000 | -212 | -43,614,000 |
| Research Training: | | | | | | |
| Continuations: | | | | | | |
| Psychiatry..... | --- | --- | 1 | 33,000 | +1 | +33,000 |
| Nursing..... | --- | --- | 1 | 17,000 | +1 | +17,000 |
| Social Work..... | --- | --- | 1 | 17,000 | +1 | +17,000 |
| Behavioral Scie. | 164 | 11,723,000 | 114 | 3,809,000 | -50 | -7,914,000 |
| Epidemiology.... | 5 | 220,000 | 5 | 112,000 | -- | -108,000 |
| Subtotal..... | 169 | 11,943,000 | 122 | 3,988,000 | -47 | -7,955,000 |
| Competing/New: | | | | | | |
| Psychiatry..... | 1 | 70,000 | --- | --- | -1 | -70,000 |
| Nursing..... | 1 | 34,000 | --- | --- | -1 | -34,000 |
| Social Work..... | 1 | 34,000 | --- | --- | -1 | -34,000 |
| Behavioral Scie. | 4 | 325,000 | --- | --- | -4 | -325,000 |
| Epidemiology.... | 1 | 56,000 | --- | --- | -1 | -56,000 |
| Scientific Eval. | -- | --- | 3 | 85,000 | +3 | +85,000 |
| Subtotal..... | 8 | 519,000 | 3 | 85,000 | -5 | -434,000 |
| Total, Res. Trng.. | 177 | 12,462,000 | 125 | 4,073,000 | -52 | -8,389,000 |
| Total, Training... | 1,142 | 80,028,000 | 878 | 28,025,000 | -264 | -52,003,000 |

III. Community Programs:

| Category and Funding Authority: | 1976 Appropriation No. | 1976 Appropriation Amount | 1977 Estimate No. | 1977 Estimate Amount | Increase or Decrease No. | Increase or Decrease Amount |
|---|---|---|---|---|---|---|
| A. New Programs under P.L. 94-63: | | | | | | |
| Planning-A202(d)..... | 20 | $1,500,000 | --- | --- | -20 | -$1,500,000 |
| Operations (1st yr. A203(d)(1)..... | 26 | 24,000,000 | --- | --- | -26 | -24,000,000 |
| Operations (continuing)-A203(d)(2)..... | -- | --- | --- | --- | --- | --- |
| Converted staffing A203(d)(2)..... | -- | --- | --- | --- | --- | --- |
| Consultation & Education-A204(c)..... | 36 | 4,000,000 | --- | --- | -36 | -4,000,000 |
| Conversion-A205(c).... | 100 | 20,000,000 | --- | --- | -100 | -20,000,000 |
| Distress financing B-213..... | 11 | 4,000,000 | --- | --- | -11 | -4,000,000 |
| Facilities Assist. C-228..... | --- | --- | --- | --- | --- | --- |
| Rape prevention & control D-231..... | A/ | A/ | --- | --- | --- | --- |
| Subtotal..... | 193 | 53,500,000 | --- | --- | -193 | -53,500,000 |
| B. Continuations from Old Legislation CMHC Act: | | | | | | |
| Staffing..... | 461 | 135,363,000 | 370 | $110,526,000 | -91 | -24,837,000 |
| Child M.H..... | 161 | 26,844,000 | 161 | 20,274,000 | --- | -6,570,000 |
| Subtotal..... | 622 | 162,207,000 | 531 | 130,800,000 | -91 | -31,407,000 |
| Total, Community Programs B/..... | 815 | 215,707,000 | 531 | 130,800,000 | -284 | -84,907,000 |

Funds provided under this activity heading are used for the improvement of the organization, allocation, and delivery of mental health services. Grants are authorized under various provisions of the Community Mental Health Centers Act as follows:

A. New Programs under P.L. 94-63:

1. Planning: Section 202 authorized funds for grants designed to (a) assess need for services; (b) design a Center based upon such an assessment; (c) assemble financial and professional assistance and support for the proposed Center program; and (d) initiate and encourage continuing community involvement in development and operation of the program.

A/ Funds in the amount of $3,000,000 were appropriated for research grants and contracts. These funds are included under the Research activity.

B/ Excludes $14,250,000 in obligations for CMHC construction, from funds appropriated prior to FY 1976.

2. Operations: Section 203 authorized appropriations to finance the cost of operations grants. This authority replaced staffing support under the old Community Mental Health Centers (CMHC) Act.

3. Conversion: Under Section 205, funds are authorized to enable Centers to meet additional costs associated with converting existing Centers to add services to the elderly, children, alcoholics, and drug abusers; assisting courts in screening residents recommended for referral to state mental hospitals; follow-up services; and halfway house services.

4. Consultation and education: Separate grants are authorized (Section 204) to provide consultation and education services to Centers which have completed four years of Federal support, and to entities which meet the definition of a Community Mental Health Center.

5. Distress: Section 213 authorizes financial distress grants to Centers terminating final Federal staffing support if, without this support, there will result an inability to provide, or a significant reduction in, the types or quality of services required under the new Act.

6. Facilities Assistance: These grants are authorized to enable a Center to acquire new facilities or remodel the existing plant. Also included are authorities to lease, construct, and initially equip such facilities.

B. Old Legislation:

Funds provided under this category are used to provide continuation support for CMHC staffing and child mental health grants awarded prior to June 30, 1975, and which have not changed to support under the new authority, 203d. The authority to continue these awards is in Section 203e.

Impact of 1977 Budget:

No funding is requested under the new authorities provided by Public Law 94-63. Funds requested will support continuation costs attributable to 531 staffing and child mental health grants awarded prior to June 30, 1975 under the old Community Mental Health Centers Act. These funds will be incorporated into a proposed health block grant program.

WORKLOAD DATA

| Capacity of Centers: | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Funded..... | 2,457,000 | 2,399,000 | -58,000 |
| Operational..... | 2,125,000 | 2,067,000 | -58,000 |
| Patients Treated: | | | |
| Children..... | 471,000 | 458,000 | -13,000 |
| Adults..... | 1,274,000 | 1,240,000 | -34,000 |
| Total..... | 1,745,000 | 1,698,000 | -47,000 |
| Population Covered by: | | | |
| Funded Centers... | 92,000,000 | 90,000,000 | -2,000,000 |
| Operational Centers | 80,000,000 | 78,000,000 | -2,000,000 |
| Number of Centers: | | | |
| Funded..... | 635 | 620 | -15 |
| Operational..... | 549 | 534 | -15 |

IV. Management and Information:

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Management & Inform. | 530 | $22,229,000 | 372 | $20,414,000 | -158 | -$1,815,000 |

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, including operation of the National Clearinghouse for Mental Health Information.

Impact of 1977 Budget:

NIMH will (1) provide technical assistance to, and consultation with, approximately 2,400 grantees, (2) review and administer approximately 5,000 grant applications; (3) respond to some 96,000 mental health inquiries; (4) add an estimated 46,000 abstracts to its files; (5) review approximately 1,800 publications for relevant mental health content; and (6) work with training institutions to assist in an orderly phase-out of the training grants program.

The $1,815,000 decrease projected for FY 1977 reflects the following changes:

... Annualization of pay raises authorized in FY 1976 (+$676,000);
... Within-grade increases (+$283,000);
... Increase in payments to the Office of Federal Employees' Compensation ($16,000);
... Additional assessments for working capital and service and supply funds (+$84,000);
... Additional postage charges (+$136,000);
... Annualization of new positions in 1976 (+$600,000);
... Program reduction of 158 positions and related support funds (-$2,370,000);
... Transfer of funds for training grant review to Training Grants activity (-$300,000);
... One less day of pay (-$50,000);
... Program decrease (-$890,000).

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II. Drug Abuse

| | 1976 Revised Pres. Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Research.. | 102 | $31,602,000 | 102 | $ 34,000,000 | 102 | $ 34,000,000 | -- | -- |
| Training.. | -- | 3,000,000 | -- | 10,000,000 | -- | 4,000,000 | -- | -6,000,000 |
| Comm.Prog. | -- | 172,962,000 | -- | 174,051,000 | -- | 195,000,000 | -- | +20,949,000 |
| Mgt.& Info | 260 | 14,674,000 | 295 | 14,121,000 | 252 | 14,827,000 | -43 | +706,000 |
| TOTAL.. | 362 | $222,238,000 | 397 | $232,172,000 | 354 | $247,827,000 | -43 | +$15,655,000 |

Narrative

The Alcohol, Drug Abuse and Mental Health Administration conducts a full range of drug abuse prevention activities through the Agency's National Institute on Drug Abuse (NIDA). In carrying out these responsibilities, NIDA (1) supports a wide range of research programs to gain new knowledge on the cause and effects of narcotic addiction and drug abuse, from fundamental research on the basic chemistry of abused substances to applied research and development activities having direct impact on treatment services; (2) supports training programs to ensure the availability of qualified manpower in drug abuse treatment, prevention and research programs; (3) assists communities to maintain treatment programs for drug abusers, providing direct project grant and contract support for a fully utilized national treatment system; (4) demonstrates new and/or more effective methods for drug abuse treatment and prevention services; and (5) collects and disseminates scientific, technical, and programmatic information on drug abuse from Federal, state and local prevention activities.

A. Research

Activity Summary

| | 1976 Appropriation | | 1977 Estimate | | Increase/Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Grants | --- | $ 23,109,000 | --- | $ 24,498,000 | --- | $ +1,389,000 |
| Contracts | --- | 8,280,000 | --- | 6,781,000 | --- | -1,499,000 |
| Subtotal | --- | 31,389,000 | --- | 31,279,000 | --- | -110,000 |
| Direct Operations: | 102 | 2,611,000 | 102 | 2,721,000 | --- | +110,000 |
| TOTAL RESEARCH | 102 | $ 34,000,000 | 102 | $ 34,000,000 | --- | --- |

Research programs of the National Institute on Drug Abuse (NIDA) are devoted to gaining new knowledge on the causes and effects of narcotic addiction and drug abuse and to using this knowledge as the basis for formulating improved methods for dealing with the problems in our society. FY 1977 funding will be maintained at the FY 1976 level, and will include support for new research initiatives in several high priority areas.

Research by Type Award

| | 1976 Appropriation | | 1977 Estimate | | Increase/Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Grants: | | | | | | |
| Regular: | | | | | | |
| Continuation..... | 187 | $13,265,000 | 127 | $ 9,545,000 | -60 | -$3,720,000 |
| Competing..... | 50 | 2,913,000 | 71 | 5,478,000 | 21 | +2,565,000 |
| New..... | 41 | 2,919,000 | 25 | 1,803,000 | -16 | -1,116,000 |
| Supplemental..... | (32) | 799,000 | (28) | 701,000 | (-4) | -98,000 |
| Subtotal..... | 278 | 19,896,000 | 223 | 17,527,000 | -55 | -2,369,000 |
| Center: | | | | | | |
| Continuation..... | 7 | 2,529,000 | 7 | 2,466,000 | -- | -63,000 |
| Competing..... | 1 | 287,000 | 7 | 3,666,000 | 6 | +3,379,000 |
| Subtotal..... | 8 | 2,816,000 | 14 | 6,132,000 | 6 | +3,316,000 |
| R.C.D.A.: | | | | | | |
| Continuation..... | 7 | 217,000 | 11 | 339,000 | 4 | 122,000 |
| New..... | 6 | 180,000 | 17 | 500,000 | 11 | 320,000 |
| Subtotal..... | 13 | 397,000 | 28 | 839,000 | 15 | 442,000 |
| TOTAL GRANTS..... | 299 | $23,109,000 | 265 | $24,498,000 | -34 | +$1,389,000 |
| Contracts: | | | | | | |
| Renewals..... | 48 | $5,098,000 | 50 | $5,548,000 | 2 | $ 450,000 |
| New..... | 29 | 3,182,000 | 9 | 1,233,000 | -20 | -1,949,000 |
| Subtotal..... | 77 | 8,280,000 | 59 | 6,781,000 | -18 | -1,499,000 |
| TOTAL RES. GRANTS AND CONTRACTS..... | 376 | $31,389,000 | 324 | $31,279,000 | -52 | -$110,000 |

Research by Program Distribution

| | 1976 Appropriation | 1977 Estimate | Increase/Decrease |
|---|---|---|---|
| Continuation: | | | |
| Epidemiology..... | $ 3,377,000 | $ 3,061,000 | -$ 316,000 |
| Etiology | 1,040,000 | 620,000 | -420,000 |
| Hazards..... | 2,894,000 | 2,464,000 | -430,000 |
| Treatment..... | 4,844,000 | 4,049,000 | -795,000 |
| Basic Research..... | 3,174,000 | 1,810,000 | -1,364,000 |
| Gen. Res. Support... | 3,034,000 | 3,089,000 | +55,000 |
| Centers..... | 2,529,000 | 2,466,000 | -63,000 |
| R.C.D.A..... | 217,000 | 339,000 | +122,000 |
| Subtotal Continuation. | 21,109,000 | 17,898,000 | -3,211,000 |
| New/Competing: | | | |
| Epidemiology..... | 3,165,000 | 1,128,000 | -2,037,000 |
| Etiology..... | 687,000 | 957,000 | +270,000 |
| Hazards..... | 1,367,000 | 1,540,000 | +173,000 |
| Treatment..... | 1,318,000 | 2,434,000 | +1,116,000 |
| Basic Research..... | 1,205,000 | 1,347,000 | +142,000 |
| Gen. Res. Support... | 2,071,000 | 1,809,000 | -262,000 |
| Centers..... | 287,000 | 3,666,000 | +3,379,000 |
| R.C.D.A..... | 180,000 | 500,000 | +320,000 |
| Subtotal New/Competing | 10,280,000 | 13,381,000 | +3,101,000 |
| Total Research..... | $31,389,000 | $31,279,000 | -$110,000 |

Impact of FY 1977 Budget

1. Grants and Contracts: Research grants are awarded to public and private nonprofit agencies, research organizations, and academic institutions. Contracts are awarded for direct research when there is an area of central importance or the requirement for rapid development of a particular methodology. In FY 1977, renewal funding will be increased to support high priority projects which will continue to advance our understanding of drug abuse. These funding mechanisms support the following major program areas:

(a) Epidemiology: The goal of epidemiology research is to determine the extent of nonmedical use and abuse of all classes of drugs. The patterns, trends and extent of drug use at national, state, and local levels are explored, with samples drawn from varied cultural and ethnic backgrounds and from differing age, sex, occupation, and other sociodemographic groups. New funding in FY 1977 will support expansion of the annual nationwide survey of non-medical drug use, and specific studies of drug abuse in industry.

(b) Etiology: These studies seek to determine the conditions which govern initiation of drug using behavior, and the maintenance of this drugseeking behavior throughout the addiction cycle. They include investigations of the effects of biological, psychological, societal, experimental, and other environmental conditions on drug abusing activities. New initiatives in this category include integrated substance studies, which explore the relationships among different forms of substance abuse (e.g., alcoholism, drug addiction, cigarette smoking and overeating, etc.) in an attempt to develop intervention techniques for the prevention and treatment of many forms of substance abuse in the same environment.

(c) Hazards: Research is conducted to determine the adverse effects of drugs on the physical and mental health of the individual, and the consequences of drug abuse on society. These programs deal with the physiological and psychological complications resulting from drug use, including the effects on such behavior and performance as driving. The primary new initiative planned for this area in FY 1977 is a prospective marihuana study. With the increasing incidence and acceptance of marihuana use in youthful populations, an intensive evaluation of long term effects is needed. Of primary concern are the medical, physiological, developmental, reproductive, genetic, psychological, and social effects of chronic marihuana use.

(d) Treatment: Treatment research seeks to determine the most effective therapeutic procedures for reducing drug abuse and its adverse consequences to the individual and to society. Included in this objective is the development and clinical evaluation of new pharmacological treatment methods, including both antagonist and substitution approaches, the development of long-acting chemotherapeutic drugs, and investigation of innovative nonpharmacological treatment methods. Also included are clinical evaluations of the relative effectiveness and differential outcomes of current treatment approaches, agents, and procedures, to determine which treatment approaches work best under different conditions. New treatment research programs planned for FY 1977 are:

Post-Treatment Patient Evaluation: NIDA will initiate a long-term evaluation of patients receiving treatment in Institute-supported programs. When completed, NIDA will be in a position to articulate post-treatment expectations and to establish a more accurate picture of the life history of the drug abuser.

Human Trials for New Narcotic Antagonists: These investigations identify promising new antagonists, developed and tested preclinically, which can best be used in treatment programs to prevent drug abuse recidivism by blocking the euphoriant effects of opiates without being addictive themselves.

Combined Pharmacological and Behavioral Therapy: Techniques based on behavioral theories, used in conjunction with chemotherapies presently available and under development, enhance the likelihood of permanently altering drug seeking behavior.

(e) Basic Research: Basic research is essential to advancing our knowledge of the pharmacology, biochemistry, and neurophysiology of abused drugs

and the mechanisms involved in drug tolerance, dependence, and addiction. It involves research on the sites and mechanisms of drug action, including studies of dependence, pain and analgesia, the storage and metabolism of abused drugs, and the mechanisms through which their behavioral effects are mediated. Major advances have been made in our understanding of the basic mechanisms involved in opiate action at the brain receptor level, thereby helping in the development of chemical compounds to ameliorate consequences of the abuse problem. New efforts will also be initiated to determine whether all substance abuse is fundamentally the same behavioral process. Another new effort will be the initiation of human trials of extended action vehicles. Chemotherapeutic treatment strategies have in the past depended upon the addict's ability to schedule his life around almost daily clinic contact. Extended action vehicles, if proved successful by these trials, will obviate the need for daily clinic attendance and facilitate the patient's pursuit of vocational and educational goals.

(f) General Research Support: General research support is provided for the development of methodological and other resources required to further drug abuse research and ensure maximum utilization of available information. This includes development of new research methodologies such as gas chromotography and mass spectrometry, the supply of controlled drugs and chemicals to the scientific community, and the maintenance of a research inventory which indicates where greater emphasis is needed.

(g) Psycho-Social/Biomedical Centers: These centers of research excellence integrate efforts of the basic and clinical researcher to hasten and amplify research findings. A high proportion of key programs in this area, including three centers previously supported by the SAODAP will be considered for renewal in FY 1977. The continuation costs for on-going programs will also be supported.

(h) Research Career Development Awards: These long-term awards to personnel with demonstrated drug abuse research potential enable the recipients to prepare for independent drug abuse research in a productive scientific environment. This budget will support the continuation costs of awards already committed, provide for 17 new projects, and thereby help ensure a competent future pool of drug abuse researchers.

2. Direct Operations: This activity supports the clinical program of the Addiction Research Center (ARC) in Lexington, Kentucky. Research is concerned with the nature of the addictive process and assessing the abuse potentiality of new analgesics and amphetamines, validation of urine testing methods, and measurement of the euphorigenic and physiologic effects of barbiturates. An extensive program related to the study of the basic modes of action of morphine and amphetamines in man is currently underway. Methods to measure the subjective effects of drugs on individuals are being developed. Increasing emphasis is being placed on deriving chemical methods for diagnosing physical dependence on drugs. The FY 1977 funding level is $2,721,000.

B. Training

Activity Summary

| | 1976 Appropriation | | 1977 Estimate | | Increase/Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Grants | 39 | $ 4,379,000 | 23 | $ 1,100,000 | -16 | -$3,279,000 |
| Contracts | 56 | 5,424,000 | 52 | 2,400,000 | -4 | -3,024,000 |
| Fellowships | 18 | 197,000 | 42 | 500,000 | +24 | +303,000 |
| TOTAL TRAINING | 113 | $10,000,000 | 117 | $ 4,000,000 | +4 | -$6,000,000 |

The National Institute on Drug Abuse (NIDA) training program seeks to ensure the continued availability of qualified manpower in drug abuse treatment, prevention, and research projects as direct Federal support is phased out. The state role in meeting future manpower needs will be strengthened through continued support for the state training support program, the National Training Center and its subsidiary regional resource centers, and provision of technical assistance to state training activities. A total of 3,775 persons will receive direct NIDA training support in FY 1977 compared to 10,561 in FY 1976, reflecting the shift of training responsibility to the states.

Training by Type Award and Program

| | 1976 Appropriation | | 1977 Estimate | | Increase/Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Clinical Training: | | | | | | |
| Grants: | | | | | | |
| Continuation | 21 | $2,469,000 | 23 | $1,100,000 | +2 | $-1,369,000 |
| Competing | --- | --- | --- | --- | --- | --- |
| New | 18 | 1,785,000 | --- | --- | -18 | -1,785,000 |
| Supplemental | (5) | 125,000 | --- | --- | (-5) | -125,000 |
| Subtotal | 39 | 4,379,000 | 23 | 1,100,000 | -16 | -3,279,000 |
| Contracts: | | | | | | |
| NDATC:* | | | | | | |
| Renewal | 1 | 2,500,000 | 1 | 1,250,000 | --- | -1,250,000 |
| Other: | | | | | | |
| Renewal | 50 | 1,500,000 | 51 | 1,150,000 | 1 | -350,000 |
| New | 5 | 1,424,000 | --- | --- | -5 | -1,424,000 |
| Subtotal | 55 | 2,924,000 | 51 | 1,150,000 | -4 | -1,774,000 |
| Subtotal Contr. | 56 | 5,424,000 | 52 | 2,400,000 | -4 | -3,024,000 |
| Subtotal Clin. Trng. | 95 | $9,803,000 | 75 | $3,500,000 | -20 | $-6,303,000 |
| Research Training: | | | | | | |
| Fellowships: | | | | | | |
| Predoctoral | | | | | | |
| Cont. | 2 | 14,000 | 2 | 14,000 | --- | --- |
| New | --- | --- | --- | --- | --- | --- |
| Subtotal | 2 | 14,000 | 2 | 14,000 | --- | --- |
| Postdoctoral | | | | | | |
| Cont. | 16 | 183,000 | 40 | 486,000 | +24 | +303,000 |
| New | --- | --- | --- | --- | --- | --- |
| Subtotal | 16 | 183,000 | 40 | 486,000 | +24 | +303,000 |
| Subtotal Fellowships | | | | | | |
| Research Training | 18 | 197,000 | 42 | 500,000 | +24 | +303,000 |
| TOTAL TRAINING | 113 | $10,000,000 | 117 | $4,000,000 | +4 | $-6,000,000 |

* National Drug Abuse Training Center

Impact of FY 1977 Budget

1. Grants: Training grants are awarded to non-profit institutions for specialized training in the prevention and treatment of narcotic addiction and drug abuse. In FY 1977 training grant support is being phased out.

2. Research Fellowships: Under the provisions of the National Research Service Award Act of 1974, NIDA supports the award of degree-oriented individual and institutional fellowships to increase the supply of biomedical and behavioral researchers. The predoctoral program will be phased out, although ongoing commitments will be met. Postdoctoral fellowships will not be phased out, although no new funds are available.

3. Contracts: Contract funds for FY 1977 will continue to support operation of the National Drug Abuse Training Center in Washington, D.C., and include three regional resource centers at reduced funding levels. This activity will further support the states in developing their own training capability by serving as a model for developing and testing training methodologies which can be applied to community drug abuse treatment, rehabilitation, and prevention programs. The state training support program will continue, at a reduced funding level, to provide management assistance in the application of standardized training design, implementation and funding methods. The state training role will be further enhanced by NIDA plans to work with single state agencies in establishing credentialing standards for all drug abuse workers, recommending minimum education and training requirements for each level and type of credential.

C. Drug Abuse Community Programs:

Activity Summary

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Proj. Grants and Contracts: | | | | | | |
| Treatment..... | 244 | $124,437,000 | 241 | $145,118,000 | -3 | +20,681,000 |
| Demonstration.. | 42 | 11,809,000 | 34 | 11,118,000 | -8 | -691,000 |
| Prev./Educ. ... | 27 | 2,805,000 | 20 | 3,764,000 | -7 | +959,000 |
| Subtotal..... | 313 | 139,051,000 | 295 | 160,000,000 | -18 | +20,949,000 |
| Formula Grants | 56 | 35,000,000 | 56 | 35,000,000 | --- | --- |
| Total Community Programs..... | 369 | 174,051,000 | 351 | 195,000,000 | -18 | +20,949,000 |

Through the projects funded under the community programs budget activity, the NIDA administers a comprehensive program of drug abuse treatment, treatment demonstration, prevention and education activities. The budget recognizes that the federal government must continue to share a large burden of the efforts in treating drug addicts and abusers. For example, more than 50% of the 271,000 treatment slot capacity in the United States is funded in whole or in part by the Federal Government. Of this, NIDA currently funds 95,000 treatment slots, or 35% of the nation's capacity. Most of these slots are currently funded with a declining matching federal share with the intent that they would become self-sufficient after a 6-8 year time period.

Impact of the 1977 Budget

As recognized in the President's White Paper on Drug Abuse, current efforts must be expanded to meet the growing demands on the nation's drug abuse treatment network. In response to the recommendations contained in this White Paper, the 1977 budget for NIDA proposes the following new initiatives in the community programs area:

- An additional 7,000 treatment slots will be supported, bringing the total number of NIDA funded treatment slots to 102,000.

- As mentioned above, treatment grants and contracts are awarded with a declining federal matching percentage. The average federal contribution was 66.9% in FY 1976. A maintenance budget is proposed in FY 1977 whereby no grantees will decline below 60% Federal support in FY 1977 with the exception of grantees already receiving less than 60% which will continue at their current rate. This will result in an average federal matching rate of 62.5%.

- A new treatment demonstration effort will be launched in FY 1977 focusing on two drugs which are being increasingly abused - amphetamines and barbiturates.

In addition to these initiatives, NIDA will continue its policies of selectively shifting drug abuse funding capacity to assure maximum utilization. The statewide contract funding mechanism will be used as extensively as possible. The dollar levels for each of the various funding mechanisms and a brief description follow:

Community Programs by Type Award

| | 1976 Appropriation | | 1977 Estimate | | Increase/Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Project Grants: | | | | | | |
| Staffing | | | | | | |
| Continuation | 23 | $10,988,000 | 23 | $13,013,000 | --- | +$ 2,025,000 |
| Supplemental | (1) | 235,000 | | --- | -(1) | - 235,000 |
| Subtotal | 23 | 11,223,000 | 23 | 13,013,000 | --- | + 1,790,000 |
| Service -8 Yr. | | | | | | |
| Continuation | 96 | 43,691,000 | 96 | 42,240,000 | --- | - 1,451,000 |
| Supplemental | (3) | 196,000 | | --- | -(3) | - 196,000 |
| Subtotal | 96 | 43,887,000 | 96 | 42,240,000 | --- | - 1,647,000 |
| Service - 3 Yr. | | | | | | |
| Continuation | 20 | 4,755,000 | 59 | 20,525,000 | +39 | + 15,770,000 |
| Competing | 65 | 22,030,000 | 20 | 4,171,000 | -45 | - 17,859,000 |
| Supplemental | (1) | 25,000 | | --- | -(1) | - 25,000 |
| Subtotal | 85 | 26,810,000 | 79 | 24,696,000 | -6 | - 2,114,000 |
| Demonstration | | | | | | |
| Continuation | 32 | 9,065,000 | 26 | 8,208,000 | -6 | - 857,000 |
| New | --- | --- | 7 | 2,000,000 | +7 | + 2,000,000 |
| Supplemental | (6) | 520,000 | --- | --- | -(6) | - 520,000 |
| Subtotal | 32 | 9,585,000 | 33 | 10,208,000 | +1 | + 623,000 |
| Prevention | | | | | | |
| Continuation | 24 | 2,397,000 | 15 | 1,744,000 | -9 | - 653,000 |
| Competing | 3 | 154,000 | --- | --- | -3 | - 154,000 |
| New | --- | --- | --- | --- | --- | --- |
| Supplemental | (3) | 65,000 | --- | --- | -(3) | - 65,000 |
| Subtotal | 27 | 2,616,000 | 15 | 1,744,000 | -12 | - 872,000 |
| Total Grants | | | | | | |
| Continuation | 195 | 70,896,000 | 219 | 85,730,000 | +24 | + 14,834,000 |
| Competing | 68 | 22,184,000 | 20 | 4,171,000 | -48 | - 18,013,000 |
| New | --- | --- | 7 | 2,000,000 | +7 | + 2,000,000 |
| Supplemental | (14) | 1,041,000 | --- | --- | -(14) | - 1,041,000 |
| Total Grants | 263 | $94,121,000 | 246 | $91,901,000 | -17 | - $2,220,000 |

| | 1976 Appropriation No. | 1976 Appropriation Amount | 1977 Estimate No. | 1977 Estimate Amount | Increase/Decrease No. | Increase/Decrease Amount |
|---|---|---|---|---|---|---|
| Contracts: | | | | | | |
| Statewide | | | | | | |
| Renewal | 24 | $39,915,000 | 27 | $48,870,000 | +3 | + $ 8,955,000 |
| Supplemental | --- | --- | (20) | 12,847,000 | +(20) | + 12,847,000 |
| Subtotal | 24 | 39,915,000 | 27 | 61,717,000 | +3 | + 21,802,000 |
| NARA* | | | | | | |
| Renewal | 13 | 1,102,000 | 13 | 1,102,000 | --- | --- |
| Technical Asst. | | | | | | |
| Renewal | 2 | 900,000 | 2 | 1,750,000 | --- | + 850,000 |
| Demonstration | | | | | | |
| Renewal | 3 | 1,076,000 | 1 | 910,000 | -2 | - 166,000 |
| New | 7 | 1,148,000 | --- | --- | -7 | - 1,148,000 |
| Subtotal | 10 | 2,224,000 | 1 | 910,000 | -9 | - 1,314,000 |
| Prev./Education | | | | | | |
| Renewal | --- | --- | 5 | 2,020,000 | +5 | + 2,020,000 |
| Supplemental | (5) | 189,000 | --- | --- | -(5) | - 189,000 |
| Subtotal | (5) | 189,000 | 5 | 2,020,000 | +5 | + 1,831,000 |
| Psych. Care | | | | | | |
| Renewal | 1 | 600,000 | 1 | 600,000 | --- | --- |
| Total Contracts: | | | | | | |
| Renewal | 43 | 43,593,000 | 49 | 55,252,000 | +6 | + 11,659,000 |
| New | 7 | 1,148,000 | --- | --- | -7 | - 1,148,000 |
| Supplemental | (5) | 189,000 | (20) | 12,847,000 | +(15) | + 12,658,000 |
| Total Contracts | 50 | 44,930,000 | 49 | 68,099,000 | -1 | 23,169,000 |
| Total Proj. Grants and Contracts: | | | | | | |
| Continuation | 238 | 114,489,000 | 268 | 140,982,000 | +30 | + 26,493,000 |
| Competing | 68 | 22,184,000 | 20 | 4,171,000 | -48 | - 18,013,000 |
| New | 7 | 1,148,000 | 7 | 2,000,000 | --- | + 852,000 |
| Supplemental | (19) | 1,230,000 | (20) | 12,847,000 | +(1) | + 11,617,000 |
| Total | 313 | 139,051,000 | 295 | 160,000,000 | -18 | 20,949,000 |
| Formula Grants | 56 | 35,000,000 | 56 | 35,000,000 | --- | --- |
| Total Com. Prog. | 369 | $174,051,000 | 351 | $195,000,000 | -18 | + $20,949,000 |

*Narcotic Addict Rehabilitation Act

Analysis Cost/Slot

| | 1976 Appropriation | | 1977 Estimate | |
|---|---|---|---|---|
| | Slots | Cost/ Slot | Slots | Cost/ Slot |
| Treatment Grants and Contracts: | | | | |
| Staffing | 9,543 | $1,238 | 9,543 | $1,298 |
| Service 8 yr. | 30,360 | 1,458 | 30,360 | 1,430 |
| Service 3 yr. | 19,517 | 1,440 | 18,247 | 1,399 |
| Statewide | 27,600 | 1,795 | 36,366 | 1,727 |
| Total Treatment | 87,020 | $1,526 | 94,516 | $1,507 |
| Other: (Slots Only) | | | | |
| NARA | 479 | | 479 | |
| Demonstration | 2,543 | | 2,395 | |
| Research Proj. | 1,700 | | 1,700 | |
| Formula Grants | 2,900 | | 2,900 | |
| Total NIDA | 94,642 | | 101,990 | |

1. Project Grants and Contracts:

   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. Staffing grant continuation funding will be provided for 23 projects in FY 1977.

   b. Service Grants: These projects provide Federal support for programs of treatment and rehabilitation which include detoxification, institutional treatment, or community-based aftercare services. Ninety-six of these programs, originally funded under Section 256 of the Community Mental Health Centers Act, are eligible for eight years of support and will receive continuation funding in 1977. Seventy-nine projects, funded since April, 1973, under Section 410 of the Drug Abuse Office and Treatment Act, will receive funding consideration in FY 1977. These projects were initially funded for three years of Federal support, with possible renewal for a total of three additional years. In FY 1977, twenty of the 79 projects will be finishing the first three years of support and will be considered for renewal. The budget includes $4,171,000 to either support these 20 projects or selectively shift funding support to other areas of the nation with a large unmet treatment need.

c. Demonstration Grants and Contracts: Demonstration projects are awarded to support and evaluate promising new theories or approaches relating to substance abuse treatment and rehabilitation services, and include the following: innovative models to improve the quality of treatment and rehabilitation services; evaluation methodologies designed to determine program effectiveness; models for financing the cost of treatment and rehabilitation; and studies which define appropriate treatment and rehabilitation approaches for client groups with unique cultural, geographical, and/or psychological characteristics. Funds for this activity also support the Drug Abuse Early Warning Network. This project is a cooperative effort with the Drug Enforcement Administration to collect data on a national basis regarding trends and extent of drug abuse. A new effort, focusing on the abuse of amphetamines and barbiturates will be launched.

d. Prevention Grants and Contracts: This program supports innovative demonstration efforts which have the potential for developing new knowledge and methodologies which provide constructive alternatives to, and can complete successfully with, the sought after pharmacological effects of drugs. During fiscal year 1977, completed demonstration efforts will provide NIDA with successful prevention strategies that can be disseminated nationally. In addition, projects will be continued which were initiated by the Special Action Office on Drug Abuse Prevention and transferred to NIDA at the expiration of the Office's authority in FY 1975. These projects provide the means for evaluating new prevention techniques and for disseminating new information to various state and local prevention efforts.

e. 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 27 states will be supported by these contracts in FY 1977 at a renewal cost of $48,870,000. The budget also includes funds for 7,000 new treatment slots to expand treatment services in states where an unmet need still exists.

f. 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 1977 to provide treatment services for addicts specifically requesting or expressly directed to this program.

g. Technical Assistance: These projects enable NIDA to monitor the efficiency of the management, fiscal, and programmatic activities of Federally-funded treatment programs, ensuring compliance with Federal funding criteria and maintenance of a fully utilized treatment capacity. Two technical assistance projects will be refunded in FY 1977 at a total project cost of $1,750,000.

2. 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, financial, and program need of each state. Federal funding through the formula grant mechanism will be maintained at $35,000,000 in FY 1977. Estimates have 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 1977 formula grants will continue to service as the mechanism through which states will assume coordinating responsibility for their drug abuse programs.

D. Management and Information:

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Management and Information..... | 295 | $14,121,000 | 252 | $14,827,000 | -43 | +$706,000 |

This activity supports the staff of the National Institute on Drug Abuse responsible for planning and implementing research, training, community service, and information programs for the prevention and control of drug abuse. The activity also supports the Integrated Drug Abuse Management Information System (IDAMIS), which serves as the organizational framework for a variety of related management information systems operated by the Institute's Division of Scientific and Program Information (DSPI).

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.

In cooperation with 53 states and territories and with the assistance of appropriate support contractors and private consultants, IDAMIS supplies program managers at the Federal, state, and local levels with accurate, timely, and useful information for planning resource allocation, monitoring, and evaluation. A variety of reports, both routine and special, are generated and distributed to appropriate individuals. IDAMIS consists of two major systems: (1) the Client Oriented Data Acquisition Process (CODAP), which is concerned with the monthly collection of client data and (2) the National Drug Abuse Treatment Utilization Survey (NDATUS), which provides information on all drug abuse treatment units regardless of source of funding. This inventory is conducted twice a year, and documents essential management data in order to rationally plan the allocation of Federal funds to support drug abuse treatment throughout the United States.

The $706,000 increase projected for FY 1977 reflects the following changes:

Management and Information:

| | |
|---|---|
| Within grade increases | +$114,000 |
| Full year cost of October '75 pay raise | +235,000 |
| Increased cost to Office of Federal Employees Compensation | +6,000 |
| Increased cost to Health, Service, and Supply Fund | +21,000 |
| Increased cost to DHEW Working Capital Fund | +10,000 |
| Increased postage charges | +88,000 |
| One less day of pay | -23,000 |
| 1977 Employment reduction | -645,000 |
| Program increase | +900,000 |
| Net change | +$706,000 |

III. Alcoholism

| | 1976 Revised Pres. Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Research.. | 12 | $ 9,696,000 | 26 | $ 11,504,000 | 26 | $ 10,000,000 | -- | -$1,504,000 |
| Training.. | -- | 6,958,000 | -- | 7,458,000 | -- | 2,000,000 | -- | -5,458,000 |
| Comm.Prog. | -- | 91,051,000 | -- | 111,908,000 | -- | 79,051,000 | -- | -32,857,000 |
| Mgt.& Info | 95 | 7,053,000 | 169 | 8,053,000 | 80 | 7,011,000 | -89 | -1,042,000 |
| TOTAL.. | 107 | $114,758,000 | 195 | $138,923,000 | 106 | $98,062,000 | -89 | -$40,861,000 |

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

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Research Grants & Contracts..... | -- | $10,236,000 | -- | $ 8,441,000 | -- | $-1,795,000 |
| Direct Operations.. | 26 | 1,268,000 | 26 | 1,559,000 | -- | +291,000 |
| TOTAL, RESEARCH | 26 | 11,504,000 | 26 | 10,000,000 | -- | -1,504,000 |

The growing public awareness of alcoholism as a major health problem, and the increasing demand for alcoholism treatment have created a greater need than ever for a broad base of knowledge concerning the nature of alcoholism and the most effective methods of treatment and prevention.

The alcohol research program consists of grants and contracts in a broad range of subject areas and the alcoholism intramural research laboratory currently located at Saint Elizabeths Hospital.

Grants are awarded to investigators affiliated with public and private nonprofit institutions. Contracts provide for research into specific areas of concern not being addressed by the grant program.

The intramural research laboratory serves as the focal point within the government for alcoholism research. The laboratory is a multidisciplinary research facility which has been developed to strengthen the overall effort in alcoholism research, and to provide training of promising investigators for career work in the field of alcoholism.

Research Grants & Contracts by Type

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Grants: | | | | | | |
| Regular: | | | | | | |
| Continuations. | 121 | $ 7,828,000 | 85 | $ 5,975,000 | -36 | $-1,853,000 |
| Competing..... | 9 | 674,000 | 8 | 600,000 | -1 | -74,000 |
| New..... | 5 | 400,000 | 5 | 400,000 | -- | --- |
| Supplemental.. | (15) | 200,000 | (15) | 200,000 | (--) | --- |
| Subtotal.... | 135 | 9,102,000 | 98 | 7,175,000 | -37 | -1,927,000 |
| Res. Scientist Develop. Awards: | | | | | | |
| Continuations | 9 | 259,000 | 12 | 316,000 | +3 | +57,000 |
| Competing.... | -- | --- | 3 | 90,000 | +3 | +90,000 |
| New..... | 7 | 175,000 | 2 | 60,000 | -5 | -115,000 |
| Subtotal.... | 16 | 434,000 | 17 | 466,000 | +1 | +32,000 |
| Subtotal, Grants | 151 | 9,536,000 | 115 | 7,641,000 | -36 | -1,895,000 |
| Contracts: | | | | | | |
| Renewal..... | 4 | 292,000 | 8 | 700,000 | +4 | +408,000 |
| New..... | 4 | 408,000 | 1 | 100,000 | -3 | -308,000 |
| Subtotal, Cont. | 8 | 700,000 | 9 | 800,000 | +1 | +100,000 |
| TOTAL, RESEARCH GRANTS & CONTRACTS | 159 | 10,236,000 | 124 | 8,441,000 | -35 | -1,795,000 |

Research Grants & Contracts by Program

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Continuations: | | | | | | |
| Biological..... | 49 | $ 2,622,000 | 27 | $ 1,765,000 | -22 | $ -857,000 |
| Clinical/Medical | 26 | 1,499,000 | 23 | 1,328,000 | -3 | -171,000 |
| Clinical/Psych.. | 15 | 1,296,000 | 17 | 1,288,000 | +2 | -8,000 |
| Behavioral..... | 20 | 1,160,000 | 13 | 636,000 | -7 | -524,000 |
| Epidemiology.... | 8 | 399,000 | 7 | 352,000 | -1 | -47,000 |
| Service Delivery | 5 | 282,000 | 3 | 177,000 | -2 | -105,000 |
| Other..... | 6 | 779,000 | 6 | 698,000 | -- | -81,000 |
| Scientific Eval. | 1 | 50,000 | 1 | 47,000 | -- | -3,000 |
| Contracts..... | 4 | 292,000 | 8 | 700,000 | +4 | +408,000 |
| Subtotal..... | 134 | 8,379,000 | 105 | 6,991,000 | -29 | -1,388,000 |
| Competing: | | | | | | |
| Biological..... | 5 | 315,000 | 7 | 450,000 | +2 | +135,000 |
| Clinical/Medical | 8 | 541,000 | 4 | 305,000 | -4 | -236,000 |
| Clinical/Psych.. | 4 | 300,000 | 3 | 285,000 | -1 | -15,000 |
| Behavioral..... | 2 | 155,000 | 2 | 155,000 | -- | --- |
| Epidemiology.... | 1 | 78,000 | 1 | 80,000 | -- | +2,000 |
| Service Delivery | 1 | 60,000 | 1 | 75,000 | -- | +15,000 |
| Other..... | -- | --- | -- | --- | -- | --- |
| Contracts..... | 4 | 408,000 | 1 | 100,000 | -3 | -308,000 |
| Subtotal..... | 25 | 1,857,000 | 19 | 1,450,000 | -6 | -407,000 |
| TOTAL, RESEARCH GRANTS & CONTRACTS | 159 | 10,236,000 | 124 | 8,441,000 | -35 | -1,795,000 |

Impact of 1977 Budget:

Grants & Contracts: A balanced program will be maintained in 1977 between biomedical and psychosocial research, with increased emphasis upon clinical research in both medical and psychological areas. Areas of emphasis to be addressed in 1977 include the following:

Within the biological and clinical/medical fields, studies will be supported to investigate the relationships between alcoholism and such physiological factors as (1) the central nervous system, (2) neuroendocrine activity, (3) pathologic conditions including cancer and diseases of the heart and liver, and (4) the fetal alcohol syndrome.

Psychological, behavioral, and epidemiological research will include studies of (1) moderate alcohol use, (2) drinking among the elderly, (3) the natural history of alcoholism as associated with changes in life situations, and (4) diagnosis and effective treatment methods.

Intramural Research: The 1977 estimate will provide salary and related costs to support the continuation of the program at the 1976 level. A description of activities currently supported in 1976 and to be continued in 1977 is provided below.

Biochemistry Program: Biochemical studies will be conducted to investigate the causes and treatment of alcoholism and diseases related to alcoholism through understanding of the metabolic and toxicologic effects of alcohol on the body.

Behavioral Program: Studies will be continued toward understanding the behavioral determinants which induce alcohol ingestion and the factors which serve to inhibit or regulate alcohol consumption. Understanding of the factors controlling alcohol intake will provide knowledge concerning deterrents and countermeasures to be used in the prevention and treatment of alcoholism.

The Neuroscience Program: Studies will be continued toward understanding the basic mechanisms governing alcoholic complications, addiction, and withdrawal, including the molecular components involved in each of these processes. In addition, studies will be made of genetic factors affected by alcohol ingestion.

B. TRAINING

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. of Awards | Amount | No. of Awards | Amount | No. of Awards | Amount |
| Training Grants | 83 | $ 7,227,000 | 38 | $ 1,769,000 | -45 | $-5,458,000 |
| Fellowships.... | 19 | 231,000 | 19 | 231,000 | -- | --- |
| TOTAL, TRAINING | 102 | 7,458,000 | 57 | 2,000,000 | -45 | -5,458,000 |

Training grants and fellowships are awarded to defray institutional costs of training facilities and to provide stipends to individuals enrolled in the training programs. Area Alcoholism Education and Training Programs, which are included as clinical training grants in the table which follows, have provided a focused assessment of the manpower needs of the States and localities.

The Institute provides support for various kinds of training at the professional and subprofessional levels, in keeping with the perceived manpower needs in the field. The types of programs supported are determined by existing service delivery systems and the need for knowledge.

Training Grants & Fellowships by Type of Award

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. of Awards | Amount | No. of Awards | Amount | No. of Awards | Amount |
| Clinical Training: | | | | | | |
| Grants: | | | | | | |
| Continuations... | 74 | $ 6,567,000 | 32 | $ 1,600,000 | -42 | $ -4,967,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 74 | 6,567.000 | 32 | 1,600,000 | -42 | -4,967,000 |
| Research Training: | | | | | | |
| Grants: | | | | | | |
| Continuations... | 9 | 660,000 | 6 | 169,000 | -3 | -491,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 9 | 660,000 | 6 | 169,000 | -3 | -491,000 |
| Fellowships: | | | | | | |
| Predoctoral: | | | | | | |
| Continuations.. | 5 | 34,000 | 5 | 34,000 | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Subtotal..... | 5 | 34,000 | 5 | 34,000 | -- | --- |
| Postdoctoral: | | | | | | |
| Continuations.. | 14 | 197,000 | 14 | 197,000 | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Subtotal..... | 14 | 197,000 | 14 | 197,000 | -- | --- |
| Subtotal..... | 19 | 231,000 | 19 | 231,000 | -- | --- |
| Total, Res. Train. | 28 | 891,000 | 25 | 400,000 | -3 | -491,000 |
| TOTAL, TRAINING | 102 | 7,458,000 | 57 | 2,000,000 | -45 | -5,458,000 |

Impact of 1977 Budget:

The 1977 estimate supports the phaseout of alcohol training grants and provides partial funding support for the continuation of existing projects. Area Alcoholism Education and Training Programs will have received two years or more of support by 1977 and will be discontinued. It is anticipated that these programs will be sustained through increased State and local funding. Existing predoctoral fellowships, although proposed for phaseout, will be continued at full funding levels, and there will be no new starts. Postdoctoral fellowships are not proposed for phaseout, and the 1977 estimate provides the full level of funds required to support the continuation of existing projects.

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C. COMMUNITY PROGRAMS

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Project Grants & Contracts..... | 356 | $56,408,000 | 231 | $33,451,000 | -125 | $-22,957,000 |
| Formula Grants | 56 | 55,500,000 | 56 | 45,600,000 | -- | -9,900,000 |
| TOTAL | 412 | 111,908,000 | 287 | 79,051,000 | -125 | -32,857,000 |

Alcoholism community programs support efforts in States and localities to develop and maintain alcoholism prevention, education, treatment and rehabilitation programs.

Direct project grants and contracts are awarded to agencies representing a variety of socio-economic, ethnic, and other groups. Categories include: Indians, poverty communities, public inebriates, drinking drivers, Blacks, Spanish-speaking American, youth and women as well as general populations.

Formula grants are allotted to each of 56 States and Territories according to a formula of need which takes into account population, per capita income and the need for more effective alcoholism programs.

Community Programs - By Program By Type

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Staffing Grants: | | | | | | |
| Noncompeting..... | 44 | $10,097,000 | -- | --- | -44 | $-10,097,000 |
| Grants & Contracts: | | | | | | |
| Grants | | | | | | |
| Occupational: | | | | | | |
| Industrial: | | | | | | |
| Noncompeting... | 20 | 3,511,000 | 22 | $ 2,643,000 | +2 | -868,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 20 | 3,511,000 | 22 | 2,643,000 | +2 | -868,000 |
| State: | | | | | | |
| Noncompeting... | 17 | 1,445,000 | 12 | 879,000 | -5 | -566,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 17 | 1,445,000 | 12 | 879,000 | -5 | -566,000 |
| Subtotal, Occup. | 37 | 4,956,000 | 34 | 3,522,000 | -3 | -1,434,000 |

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| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Indian: | | | | | | |
| Noncompeting.... | -- | --- | -- | --- | -- | --- |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- 1/ | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | -- | --- | -- | --- | -- | --- |
| Public Inebriate: | | | | | | |
| Noncompeting.... | 17 | 5,979,000 | 19 | 3,726,000 | +2 | -2,253,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 17 | 5,979,000 | 19 | 3,726,000 | +2 | -2,253,000 |
| Drinking Driver: | | | | | | |
| Noncompeting.... | 15 | 2,074,000 | 12 | 1,388,000 | -3 | -686,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 15 | 2,074,000 | 12 | 1,388,000 | -3 | -686,000 |
| Poverty: | | | | | | |
| Noncompeting.... | 14 | 1,771,000 | 17 | 2,143,000 | +3 | +372,000 |
| Competing..... | 100 | 5,158,000 | -- | --- | -100 | -5,158,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 114 | 6,929,000 | 17 | 2,143,000 | -97 | -4,786,000 |
| Project Demo: | | | | | | |
| Noncompeting.... | 75 | 17,443,000 | 110 | 15,982,000 | +35 | -1,461,000 |
| Competing..... | 2 | 247,000 | -- | --- | -2 | -247,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 77 | 17,690,000 | 110 | 15,982,000 | +33 | -1,708,000 |
| Prevention: | | | | | | |
| Noncompeting.... | 34 | 3,990,000 | 22 | 2,344,000 | -12 | -1,646,000 |
| Competing..... | -- | --- | -- | --- | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 34 | 3,990,000 | 22 | 2,344,000 | -12 | -1,646,000 |
| Uniform Act: | | | | | | |
| Noncompeting.... | 16 | 2,762,000 | 16 | 2,546,000 | -- | -216,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Subtotal..... | 16 | 2,762,000 | 16 | 2,546,000 | -- | -216,000 |

1/ The 1976 column shows no funds for Indian programs, although actual awards will be made by NIAAA in 1976. This was done to put the budgets for both years on a comparable basis.

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Subtotal, Grants: | | | | | | |
| Noncompeting.... | 208 | 38,975,000 | 230 | 31,651,000 | +22 | -7,324,000 |
| Competing..... | 102 | 5,405,000 | -- | --- | -102 | -5,405,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental.... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 310 | 44,380,000 | 230 | 31,651,000 | -80 | -12,729,000 |
| Project Contracts: | | | | | | |
| Incentive: | | | | | | |
| Noncompeting... | 1 | 131,000 | -- | --- | -1 | -131,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Subtotal..... | 1 | 131,000 | -- | --- | -1 | -131,000 |
| Tech. Assistance: | | | | | | |
| Noncompeting... | 1 | 1,800,000 | 1 | 1,800,000 | -- | --- |
| New..... | -- | --- | -- | --- | -- | --- |
| Subtotal..... | 1 | 1,800,000 | 1 | 1,800,000 | -- | --- |
| Subtotal, Contr: | | | | | | |
| Noncompeting..... | 2 | 1,931,000 | 1 | 1,800,000 | -1 | -131,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Subtotal..... | 2 | 1,931,000 | 1 | 1,800,000 | -1 | -131,000 |
| Subtotal, G. & C.: | | | | | | |
| Noncompeting..... | 210 | 40,906,000 | 231 | 33,451,000 | +21 | -7,455,000 |
| Competing..... | 102 | 5,405,000 | -- | --- | -102 | -5,405,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental..... | (--) | --- | (--) | --- | (--) | --- |
| Subtotal..... | 312 | 46,311,000 | 231 | 33,451,000 | -81 | -12,860,000 |
| Total Community Proj.: | | | | | | |
| Noncompeting..... | 254 | 51,003,000 | 231 | 33,451,000 | -23 | -17,522,000 |
| Competing..... | 102 | 5,405,000 | -- | --- | -102 | 5,405,000 |
| New..... | -- | --- | -- | --- | -- | --- |
| Supplemental..... | (--) | --- | (--) | --- | (--) | --- |
| Total..... | 356 | 56,408,000 | 231 | 33,451,000 | -125 | -22,957,000 |
| Formula Grants..... | 56 | $55,500,000 | 56 | $45,600,000 | -- | $-9,900,000 |
| TOTAL, COMMUNITY PROGRAMS | 412 | 111,908,000 | 287 | 79,051,000 | -125 | -32,857,000 |

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Estimate of Program Beneficiaries

| | 1976 Appropriation | 1977 Estimate |
|---|---|---|
| Project Grants & Contracts: | | |
| Initial Contacts..... | 200,000 | 95,000 |
| Patients Treated..... | 160,000 | 76,000 |
| Formula Grants: | | |
| Initial Contacts..... | 95,000 | 80,000 |
| Patients Treated..... | 76,000 | 64,000 |

The 1976 appropriation provides continuation or renewal support for all community projects initiated in fiscal year 1975 and before. Any new funds would be used to award continuation grants occurring in the transition quarter in order to reduce the existing deficit. Emphasis continues to be 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. Included are projects serving women, youth, Blacks, Spanish-speaking Americans, migrant workers, public inebriates and criminal justice populations. In addition, programs are supported which meet the particular needs of employed alcoholics and drinking drivers. The Institute will also continue projects supporting community alcoholism prevention activities.

In 1976, the NIAAA will continue funding of a technical assistance contract to provide close monitoring and furnish management and program assistance to grantees. In addition, continuation will be provided to 16 States to support their efforts aimed at decriminalizing alcohol abuse under the Uniform Alcoholism Intoxication and Treatment Act.

The amount appropriated for formula grants in 1976 will serve an estimated 95,000 individuals. Based on historical experience, it is estimated that State-supported treatment efforts will comprise about 67% of the total formula grant dollars. Remaining funds are to be used for prevention and education programs, analysis and evaluation, and administrative costs.

Impact of 1977 Budget:

The 1977 estimate provides for the transfer of 151 Indian alcoholism treatment programs totaling $12 million to the Indian Health Service. The NIAAA will provide staff assistance to the IHS in order to assure the long range success of these Indian alcoholism treatment facilities under the technical guidance of alcoholism professionals. Both the 1976 and 1977 columns show no funds for Indian programs, although actual awards will be made by NIAAA in 1976. This was done to put the budgets for both years on a comparable basis.

In 1977, it is proposed that all remaining project and formula grant dollars will be transferred from the Institute and awarded to the States under a proposed consolidated State health bloc grant program. The distribution shown on the above table for 1977 would provide funding for three years for community assistance project grants.

D. MANAGEMENT & INFORMATION

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Management and Information | 169 | $ 8,053,000 | 80 | $ 7,011,000 | -89 | $-1,042,000 |

This activity includes the salaries and related expenses of the staff who plan, direct, coordinate and administer the programs carried on by the Institute, with the exception of the intramural research program, which is included under the research budget activity. Also included are the National Clearinghouse for Alcohol Information, the National Center for Alcohol Education and in 1976 a number of smaller contracts supporting a variety of Institute programs.

The $1,042,000 decrease projected for FY 1977 reflects the following changes:

...Annualization of pay raises authorized in FY 1976 (+$140,000);
...Within-grade increases (+$60,000);
...Annualization of 1976 positions increase (+$975,000);
...Increase in payments to the Office of Federal Employees' Compensation (+$3,000);
...Additional assessments for working capital and service and supply funds (+$14,000);
...Additional postage charges (+$24,000);
...Reduction of 89 positions and related support funds (-$1,335,000);
...Program decrease (-$913,000);
...One less day of pay (-$10,000)

Major Contracts by Type

| | 1976 Appropriation | | 1977 Estimate | | Increase/ Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Nat'l Center for Alcohol Education | 1 | $ 799,000 | 1 | $ 386,000 | -- | $ -413,000 |
| Nat'l Clearinghouse for Alcohol Inform. | 1 | 1,000,000 | 1 | 700,000 | -- | -300,000 |
| Program Support Contracts..... | 3 | 200,000 | -- | --- | -3 | -200,000 |
| TOTAL | 5 | 1,999,000 | 2 | 1,086,000 | -3 | -913,000 |

Impact of 1977 Budget:

In 1977, the Institute will reduce the number of staff from 169 to 80 positions. The 1977 estimate will provide for the continuation, at a reduced level, of the National Clearinghouse for Alcohol Information and the National Center of Alcohol Education.

## IV. Buildings and Facilities

| | 1976 Appropriation | 1977 Estimate | Increase/Decrease |
|---|---|---|---|
| Buildings and Facilities..... | $13,558,000 | --- | $13,558,000 |
| (B.A.)..... | (10,600,000) | --- | (10,600,000) |

Direct construction and facility improvement projects relating to facilities of the Alcohol, Drug Abuse, and Mental Health Administration are funded under this activity. Although funds in this activity are available for support of capital improvements of all ADAMHA facilities, all funds will be utilized for work at Saint Elizabeth's Hospital.

Of this $13,558,000 available in FY 1976, $2,958,000 represents the balance of funds available from previous years' appropriations for repair and maintenance to Saint Elizabeth's Hospital. These funds will be used to remedy major deficiencies in the areas of safety, patient privacy, services to patients, and air conditioning. $125,000 will fund a contract to develop a master plan for the Saint Elizabeth's site. The master plan will recommend a course of action for (1) updating existing buildings where feasible and for the provision of new facilities to meet current needs, and (2) the orderly, efficient, and economical development of the Hospital's site to accommodate changing requirements.

Of the $10.6 million in new obligational authority, $5.4 million was recommended by Congress to correct deficiencies cited by the Joint Commission on Accreditation of Hospitals in its 1974 report. Of this amount, $2.9 million will be used to develop architectural plans and drawings for additional patient space for 800 beds which is necessary to relieve overcrowding. The remaining funds will be used to install fire detection and alarm systems, improve patient privacy by installing closet and drawer equipment, and improve services to patients, particularly, the laundry rooms, the pharmacy, and modifying nursing stations.

The remaining $5.2 million will be requested in a supplemental appropriation in response to additional deficiencies cited in the 1975 JCAH Accreditation report. Most of these items related to fire protection and include the following: construction of fire doors, fire proofing of corridor doors, installation of fire stops and separations, installation of fixed wire glass windows, enclosing stairwells, installing exit signs, improving exits in patient buildings, installing special exits for handicapped patients, and improvement of emergency lighting and wiring.

Impact of 1977 Budget

A $75,000,000 buildings and facilities appropriation to regain accreditation of the Hospital will be included in a separate legislative proposal whose goal will be the eventual transfer of the Hospital to the District of Columbia.

## V. Program Direction

| | 1976 Revised Pres. Budget | | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Stand. Level User Charges (SLUC).. | -- | $ 1,532,000 | -- | $ 1,532,000 | -- | $2,550,000 | -- | $1,018,000 |
| Other Exp. | 343 | 9,831,000 | 354 | 9,831,000 | 338 | 10,678,000 | -16 | +847,000 |
| TOTAL.. | 343 | $11,363,000 | 354 | $11,363,000 | 338 | $13,228,000 | -16 | +$1,865,000 |

### Narrative

This activity, authorized by Section 301 of the Public Health Service Act, includes funds for the following purposes:

| | 1976 Appropriation | | 1977 Estimate | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| A. Staff support for the Office of the Administrator, Alcohol, Drug Abuse and Mental Health Administration..... | 200 | $5,833,000 | 184 | $6,366,000 |
| B. Staff support for Agency positions assigned to the DHEW Regional Offices..... | 154 | 3,998,000 | 154 | 4,312,000 |
| C. Rental cost for buildings occupied by Agency staff..... | --- | 1,532,000 | --- | 2,550,000 |
| Total..... | 354 | 11,363,000 | 338 | 13,228,000 |

The staff of the Office of the Administrator is responsible for overall direction and management of ADAMHA. Functions include administrative management, program planning and evaluation, program coordination, and public affairs activities. Efforts are underway in the areas of National Health Insurance, services financing, quality assurance, and technical assistance. The FY 1977 Estimate includes the transferring of 23 positions from the Public Health Service in accordance with the decentralization of the Personnel Office to the Agency. A comparable adjustment has been made in the FY 1976 Appropriation to reflect this reorganization.

Regional Offices provide technical assistance on agency programs to state and community institutions. Major efforts in the regions have included technical assistance to CMHC's to increase third party payments, improve management, cost accounting and record keeping systems. With the implementation of the proposed consolidated state health bloc grant program for mental health and alcohol community service projects, technical assistance efforts will be made in the Regional Offices to assist the states on initiating, developing, and managing the new programs. In addition, a total of 29 regional office positions formerly budgeted in the Office of the Assistant Secretary for Health (OASH) are now funded in ADAMHA in accordance with decentralization requested in the Senate report. A comparable adjustment has been made in the FY 1976 Appropriation to reflect this reorganization.

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The Public Building Amendment of 1972 (P.L. 93-313) requires each agency occupying space assigned by GSA to reimburse them for space. In 1976, the Congress appropriated funds at the 1975 level for Program Direction. In doing so, a total of $1,532,000 was appropriated for rental charges. However the 1976 actual charges will be $2,265,000. This deficiency will be absorbed by the Institutes in FY 1976 since this line item includes funds for all of the Agency's buildings. The 1977 request is $2,550,000, an increase of $1,018,000 over the amount appropriated in FY 1976.

The overall increase of $1,865,000 for FY 1977 includes the $1,018,000 for rental of space as well as the following mandatory increases and decreases:

| | | |
|---|---|---|
| 1. | Full year cost of October 1975 pay raise | +$536,000 |
| 2. | Within grade increases | +173,000 |
| 3. | Increased payment to Office of Federal Employee Compensation | +4,000 |
| 4. | Increased cost of Health, Services and Supply Fund | +165,000 |
| 5. | Increased cost of DHEW Working Capital Fund | +8,000 |
| 6. | Increased postage charges | +149,000 |
| 7. | One less day of pay | -28,000 |
| 8. | 1977 position reduction | -160,000 |

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Research (PHS Act, Section 301 and 303; Part D, Community Mental Health Centers Act)

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | Authorization | Budget Estimate | |
| Pos. | Amount | | Pos. | Amount |
| 373 | $92,908,000 | PHS (Indefinite) | 358 | $83,000,000 |
| | 3,000,000 | CMHC ($10,000,000) | | --- |
| | 95,908,000 | | | 83,000,000 |

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. 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 1976: A total of 439 new and competing awards will be funded during 1976. Areas of study will include (1) emotional, depressive and learning disorders among children and adolescents; (2) services research relating to problems of deinstitutionalization and mental health problems of the elderly; (3) various aspects of schizophrenia, including special problems relating to children, psychosocial adjustments after hospitalization, and relationships with problems of genetics and the central nervous system; (4) several depression studies which will address problems of clinical diagnosis, causation, and the effectiveness of various therapeutic and chemical treatment methods; (5) studies of minority mental health problems, with emphasis upon effects of racism and improvement of research methods; (6) research initiatives in the areas of female crime and delinquency; (7) research into the factors relating to the causes and mental health implications of rape; and (8) further development of a major intramural research finding relating to measurement of brain activity through glucose consumption.

Objectives for 1977: A total of 451 new and competing awards will be funded in 1977. Most of these resources will be devoted to further development of new initiatives undertaken during 1976. In addition, new research initiatives will focus on borderline schizophrenia and development of new therapeutic modalities specifically applicable to minority populations. Intensified research will be directed toward study of the factors which influence the development and course of depression.

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

| 1976 Appropriation | | 1977 Estimate | | | |
|---|---|---|---|---|---|
| | | Act & Sec. | Authorization | Budget Estimate | |
| Pos. | Amount | | | Pos. | Amount |
| --- | $15,134,000 | A/ | Expired | --- | $5,510,000 |
| --- | 69,966,000 | B/ | Indefinite | --- | 24,490,000 |
| --- | $85,100,000 | | | --- | 30,000,000 |

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: Training grants defray institutional costs of grantees (personnel, supplies, travel, equipment, etc.) and provide stipends and other allowances for individuals enrolled in training programs. Hospital staff development grants are designed to increase the effectiveness of staff in mental hospitals, and to translate new knowledge into more effective mental health services to patients. Fellowships are awarded to researchers in areas where there is a demonstrated national need for research manpower.

Accomplishments in 1976: During the current year, a total of 1,142 regular training grants will be supported, including 29 new and competing awards. In the fellowship area, 93 new awards will be made out of a total of 224. The Hospital staff development program will support a total of 96 awards, including 39 new.

Objectives for 1977: The 1977 budget reflects a proposal to initiate a phase-out of all training programs, except for postdoctoral fellowships. No funds will be available for new awards in the latter area, however.

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A/ National Research Service Award Act of 1974 (section 472) for research training (authority expired June 20, 1974).

B/ Public Health Service Act (Section 303) for clinical training.

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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).

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | ($14,250,000)* | Expired | --- | --- |

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. The expired authority for this program (Section 201 of the Community Mental Health Centers Act) has been supplanted by the Facilities Assistance provision under Section C-228 of Public Law 94-63.

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 areas served has been designated as a "poverty area".

Accomplishments in 1976: No new funds were requested for 1976. An estimated 72 awards will be made from $14,250,000 in unobligated funds carried forward from 1975. These funds were appropriated prior to passage of Public Law 94-63.

Objectives for 1977: No appropriations are requested in 1977.

* Obligations from prior-year appropriations.

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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 203e, Community Mental Health Centers Act as amended 1975).

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | Authorization | Budget Estimate | |
| Pos. | Amount | | Pos. | Amount |
| --- | $135,363,000 | Sums Necessary | --- | $110,526,000 |

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 were 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 1976: Funds requested for 1976 will support an estimated 461 continuation awards for programs initiated prior to expiration of the old CMHC authority on June 30, 1975.

Objectives for 1977: Funds requested will support an estimated 370 continuation awards for programs initiated under the old authority. The President's Budget proposes consolidation of all community mental health center's efforts into block grants.

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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 203e, Community Mental Health Centers Act)

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | Authorization | Budget Estimate | |
| Pos. | Amount | | Pos. | Amount |
| --- | $26,844,000 | Sums Necessary | --- | $20,274,000 |

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 1976: Funds requested for 1976 will support an estimate 161 continuation awards for programs initiated prior to expiration of the old CMHC authority on June 30, 1976.

Objectives for 1977: Funds requested will support an estimated 161 continuation awards for programs initiated under the old authority. The President's Budget proposes consolidation of all community mental health center's efforts into block grants.

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ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Operations of CMHC's - (P.L. 94-63 - Community Mental Health Centers Amendments of 1975 - Title II - Part A - Sections 202(d), 203(d)(1), 204(c) and 205(c); Part B - Section 213.

| 1976 Appropriation | | 1977 Estimate | | | |
|---|---|---|---|---|---|
| | | | | Budget Estimate | |
| Pos. | Amount | Authorization | | Pos. | Amount |
| --- | $1,500,000 | Part A-202(d) | $ 3,750,000 | --- | --- |
| --- | 24,000,000 | Part A-203(d)(1) | $55,000,000 | --- | --- |
| --- | 4,000,000 | Part A-204(c) | $15,000,000 | --- | --- |
| --- | 20,000,000 | Part A-205(c) | $20,000,000 | --- | --- |
| --- | 4,000,000 | Part B-213 | $15,000,000 | --- | --- |
| --- | 53,500,000 | | | --- | --- |

Purpose: This activity supports grants and contracts authorized under the Health Services and Nurse Training Act of 1975 (Public Law 94-63). The purpose of programs funded under this activity is 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).

Explanation: Funds made available under the new legislation are intended to stimulate a level of mental health services which is broader than the coverage under the recently expired Community Mental Health Centers Act. Among the innovative features of the new legislation are a requirement for provision of additional types of services to the community; a distress grant mechanism; several new compliance features; and requirements for state mental health plans. The funding mechanisms which are new to this program include:

... Planning grants for development of a viable community treatment program;
... Grants for initial operations, which replace the staffing and child mental health grants under the old legislation (unlike its predecessors, the operations grant is based upon a percentage of total operating costs, rather than professional staff salaries);
... Separately identifiable grants for the provision of consultation and education services;
... Conversion grants, to help Centers to meet the higher costs of converting to the new, more comprehensive service requirements;
... Financial distress grants, for centers ending their period of Federal support and are faced with a need to reduce their level of operations;
... Facilities assistance for the acquisition, remodeling, leasing, expansion, renovation, or equipping of centers; and

Accomplishments in 1976: Supplemental funds appropriated in 1976 will provide for 20 planning grant awards; 26 first-year operations grants; 36 consultation and education grants; 100 conversion awards; and 11 distress grants.

Objectives for 1977: No funds are requested for continuation of this program in 1977. The President's Budget proposes consolidation of all community mental health center's efforts into block grants.

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).

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 530 | $22,229,000 | Indefinite | 372 | $20,414,000 |

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, maintenance of Institute relationship with other branches of the Administration - and with state and community organizations.

Accomplishments in 1976: Technical assistance to, and consultation with, approximately 3,000 grantees; review and administration of approximately 5,500 grant applications; response to 96,000 mental health inquiries; and review of 1,800 publications for relevant mental health content.

Objectives for 1977: NIMH will (1) provide technical assistance to, and consultation with, approximately 2,400 grantees; (2) review and administer approximately 5,000 grant applications; (3) respond to some 96,000 mental health inquiries; (4) add an estimated 46,000 abstracts to its files; (5) review approximately 1,800 publications for relevant mental health content; and (6) work with training institutions to assist in an orderly phase-out of the training grants program.

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)

| 1976 | | 1977 | | | | |
|---|---|---|---|---|---|---|
| Appropriation | | | | | Budget Estimate | |
| Pos. | Amount | Act | Sec. | Authorization | Pos. | Amount |
| 102 | $34,000,000 | PHS | 301 | Indefinite | 102 | $34,000,000 |

Purpose: This subactivity supports drug abuse research grant and contract programs of the National Institute on Drug Abuse (NIDA) and operation of the Addiction Research Center located in Lexington, Kentucky. These programs 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 competitively awarded for directed research activities when rapid development of a particular methodology is required. In addition, research career development awards are made to increase the nation's scientific manpower for drug abuse research activities. Intramural research is supported at the Addiction Research Center, whose primary function is to test drugs for their abuse potential prior to being made available for general use.

Accomplishments in 1976: During 1976 NIDA provided support for 376 research grants and contracts, of which 249 were continuations. NIDA completed preliminary testing of long-acting methadone substitutes and safer, more effective, narcotic antagonists; developed several potentially useful new sustained-release drug delivery mechanisms; published new findings on the nature and extent of heroin addiction and marihuana abuse; developed improved knowledge and techniques for the treatment of pregnant narcotic addicts and their newborn children; and initiated a system to aid in research coordination and planning.

Objectives for 1977: The FY 1977 request provides funding support for the following new research programs: (1) large-scale human trials of long-acting methadone and narcotic antagonists; (2) an extensive prospective evaluation of the long-term effects of chronic marihuana use; (3) the development of new treatment methods utilizing chemotherapy combined with behavior modification techniques; (4) exploration of the common elements surrounding a variety of substance abuse activities, and the potential of integrating appropriate treatment methods; (5) a long-term evaluation of patients receiving treatment in Institute supported programs to enable NIDA to better articulate national post-treatment expectations. In addition, the research career development award program will be expanded, and increased emphasis will be placed on continuing research efforts concerning the psychosocial causes and effects of drug addiction and abuse. The budget provides funding for 195 continuation projects and 129 new and competing projects.

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, Section 301, 303, and National Research Service Award Act of 1974, Section 472)

| 1976 Appropriation | | 1977 | | | Budget | Estimate |
|---|---|---|---|---|---|---|
| Positions | Amount | Act | Sec. | Authorization | Pos. | Amount |
| --- | $ 4,379,000 | PHS | 303 | Indefinite | --- | $ 1,100,000 |
| --- | 5,424,000 | PHS | 301 | Indefinite | --- | 2,400,000 |
| --- | 197,000 | NRSA | 472 | Expired 1/ | --- | 500,000 |
| --- | $10,000,000 | | | | --- | $ 4,000,000 |

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, and allows NIDA to provide technical assistance to single state agencies in the development of state drug abuse training programs.

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. Other contracts are awarded to single state agencies to assist in the development of state training programs. Fellowships are awarded in support of research training.

Accomplishments in 1976: 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. In FY 1976 NIDA funded 39 training grants and 18 research training fellowships.

Objectives for 1977: The NDATC 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 increased state responsibility for training of treatment personnel, it will no longer be necessary for NIDA to continue to fund the regional training centers. All training grants and predoctoral fellowships will be phased out. Postdoctoral fellowships will be continued although no new awards will be made.

1/ Authorizing legislation to be submitted.

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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 203e; Drug Abuse Office and Treatment Act of 1972, Section 410; Narcotic Addict Rehabilitation Act, Section 607; and Public Health Service Act, Section 301)

| 1976 Appropriation | | 1977 | | | Budget Estimate | |
|---|---|---|---|---|---|---|
| Positions | Amount | Act | Sec. | Authorization | Pos. | Amount |
| --- | $11,223,000 | CMHC | 203e | "Sums as Nec." | --- | $13,013,000 |
| --- | 126,126,000 | DAOT | 410 | Expired 1/ | --- | 145,285,000 |
| --- | 1,102,000 | NARA | 607 | "Sums as Nec." | --- | 1,102,000 |
| --- | 600,000 | PHS | 301 | Indefinite | --- | 600,000 |
| --- | $139,051,000 | | | | --- | $160,000,000 |

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, institutional, or community-based aftercare services.

Accomplishments in 1976: A total of 313 awards were made of which 238 were continuations and 68 were competing renewals. Seven new demonstration contracts were funded. The major objectives in FY 1976 were to maintain full utilization of the 95,000 Federally funded treatment slots and to assure compliance with national treatment standards. Concurrent with the increase in treatment utilization at the community level, the Federal patient care provided under the Narcotic Addict Rehabilitation Act was reduced. In addition, FY 1976 witnessed continued usage of statewide service contracts as a means of promoting direct administrative responsibility for treatment at the local level.

Objectives for 1977: In FY 1977, the National Institute on Drug Abuse (NIDA) has requested sufficient funds to be able to adopt a "maintenance" treatment budget in which a fully utilized 102,000 treatment slot ceiling will be maintained. This maintenance budget enables NIDA to support treatment projects at the prevailing declining match basis until the funding level for any given project is equal to 60 percent NIDA and 40 percent local share. NIDA will continue to shift treatment service resources from project grants to statewide service contracts where appropriate. Some shifting of funded treatment capacity among communities is planned to more effectively utilize resources. New demonstration resources will be used to fund projects intended to determine the most effective prevention, treatment and rehabilitation methods for abusers of amphetamines and barbiturates. Technical assistance to the states will continue in preparation for their increased prevention responsibilities. Compliance with national treatment standards for upgrading both quality and efficacy of treatment services will be monitored. A new treatment demonstration program will be initiated to address abuse of amphetamines and barbiturates.

1/ Authorizing legislation is pending

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)

| 1976 Appropriation | | 1977 | | | Budget Estimate | |
|---|---|---|---|---|---|---|
| Positions | 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 1976: During FY 1976 formula grants continued to serve 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 1976 the states refined their second year plans to reflect new incidence and prevalence data, additional needs, and to identify adequate resources to meet them. Considerable emphasis was also placed on evaluation of ongoing programs in the state. An analysis of these plans indicates that approximately 13 percent of the funds will be used for treatment services, with the remainder being used to fund other prevention activities.

Objectives for 1977: In FY 1977 the states will again be encouraged to address the problem of quality care in the treatment and rehabilitation centers. Additionally, states will continue to develop third party funding sources for treatment of drug abuse. State agencies will also expand their coordination activities for various drug related services within their jurisdiction. All 56 states and territories will be encouraged to revise their plans where necessary to reflect current drug abuse needs and priorities.

1/ Authorizing legislation is pending.

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)

| 1976 | | 1977 | | | | |
|---|---|---|---|---|---|---|
| Appropriation | | | | | Budget Estimate | |
| Positions | Amount | Act | Sec. | Authorization | Pos. | Amount |
| 295 | $14,121,000 | PHS | 301 | Indefinite | 252 | $14,827,000 |

Purpose: Funding is provided for the overall planning, direction, administration, and coordination of the National Institute on Drug Abuse's (NIDA) treatment, rehabilitation, research, training, education, and information programs.

Explanation: This subactivity provides support for NIDA including personnel for planning, coordination, analysis, evaluation, and general administrative management. It supports the activities of the Integrated Drug Abuse Management Information System (IDAMIS) 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 1976: During FY 1976 the Institute strengthened it national data retrieval system of scientific and technical information to enable all states to assume primary responsibility for planning and coordinating their drug abuse activities. The biannual drug abuse treatment utilization survey was further refined to assist both NIDA and the states in forecasting treatment resource requirements for existing and future treatment services. The Client Oriented Data Acquisition Process (CODAP) was improved through close collaboration with state government officials to assure that they have a reasonable and independent data processing capability to use and benefit from CODAP data.

Objectives for 1977: The CODAP system will enhance its responsiveness to new information needs by increasing its reporting rate; improving data quality; completing a validation study and data analysis; and creating an historical file. The treatment utilization survey system will continue to provide management with necessary and timely information to determine in what locations treatment services are needed; analyze general treatment utilization trends; conduct comparative analyses for the nation, regions, and states; provide each state with a computer produced listing of all reported drug abuse treatment service units which can be developed into a state directory; and provide the states with technical assistance to ensure that they have the capability to analyze and use utilization survey data to generate program level management reports.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, & Mental Health

Program Purpose & Accomplishments

Activity: Alcoholism - Research - (Public Health Service Act, Section 301).

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 26 | $ 11,504,000 | Indefinite | 26 | $ 10,000,000 |

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 1976: During 1976, the NIAAA provided support for 159 grants and contracts, including 134 continuation awards. Nine of the continuation awards were for the research scientist development program. A total of 25 new and competing renewal awards were made, of which 7 were research scientist development awards. Competing awards were targeted to (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) psychological studies on environmental, genetic and psychological factors associated with the use of alcohol.

Objectives for 1977: In FY 1977, NIAAA will maintain a balanced program between biomedical and psychosocial research. Biomedical studies will be supported to investigate the relationships between alcoholism and such physiological factors as (1) the central nervous system, (2) neuroendocrine activity, (3) pathologic conditions including cancer and diseases of the heart and liver, and (4) the fetal alcohol syndrome. Psychosocial research studies will include (1) moderate alcohol use, (2) drinking among the elderly, (3) the natural history of alcoholism as associated with changes in life situations, and (4) diagnosis and effective treatment methods. The Intramural Research Program will continue at the 1976 level to serve as the focal point within the government for alcoholism research.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse & Mental Health

Program Purpose & Accomplishments

Activity: Alcoholism - Training - (Public Health Service Act, Section 303, 472).

| 1976 Estimate | | 1977 | | | | |
|---|---|---|---|---|---|---|
| | | | | | Budget Estimate | |
| Pos. | Amount | Act | Sec. | Authorization | Pos. | Amount |
| -- | $ 6,567,000 | PHS | 303 | Indefinite | -- | $ 1,600,000 |
| -- | 891,000 | NRSA | 472 | Expired 1/ | -- | 400,000 |
| | 7,458,000 | | | | | 2,000,000 |

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 have been 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 1976: During 1976, the NIAAA provided continuation support to 83 training grants and 19 research fellowships.

Objectives for 1977: In 1977, the NIAAA will provide continuation funding under phaseout policy at a reduced level to honor prior commitments in the area of training grants. Support for Area Alcoholism Education and Training Programs will be discontinued. The predoctoral fellowship program will be phased out. Continuation commitments will be honored at their full funding levels. The postdoctoral fellowship program will not be phased out, but no new awards are proposed. It is anticipated that a total of 38 continuation grants will be awarded, plus continuation support for 19 fellowships.

1/ Authorizing legislation is pending.

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 203e).

| 1976 Estimate | | 1977 | | | | |
|---|---|---|---|---|---|---|
| | | | | | Budget Estimate | |
| Pos. | Amount | Act | Sec. | Authorization | Pos. | Amount |
| -- | $ 10,097,000 | CMHC | 203e | "Sums as nec." | -- | --- |
| -- | 43,549,000 | 1/ | 311 | Expired 2/ | -- | $30,905,000 |
| -- | 2,762,000 | 1/ | 304 | $13,000,000 | -- | 2,546,000 |
| | 56,408,000 | | | | | 33,451,000 |

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 1976: During 1976, the NIAAA made a total of 356 awards, including 102 competing awards. Funds normally available for new awards would be used to award continuation grants occurring in the transition quarter to reduce the existing deficit. High priority areas include programs targeted to high risk, poverty and minority populations where services have traditionally been lacking. These include 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 1976, the NIAAA continued funding of a technical assistance contract to provide close monitoring and furnish management and program assistance to grantees. In addition, continuation was provided to 16 States for implementation of the Uniform Alcoholism and Intoxication Treatment Act.

Objectives for 1977: In 1977, 151 existing Indian projects will be transferred to the Indian Health Service. Remaining project and formula grant monies are proposed for incorporation into a newly proposed consolidated State health bloc grant program. The level of funding provided would be sufficient to support continuation awards for community assistance project grants in their second or third year.

1/ Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended.

2/ Authorizing legislation is pending.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse & Mental Health

Program Purpose & Accomplishments

Activity: Alcoholism - Community Programs - Grants to States (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Section 301).

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $ 55,500,000 | Expired 1/ | -- | $ 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 1976: In 1976, 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 1977: In 1977, a plan of utilization similar to that in FY 1976 is anticipated, at a reduced level. The President's budget proposes consolidation of the program into a comprehensive bloc grant for health.

1/ Authorizing legislation is pending.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse & Mental Health

Program Purpose & Accomplishments

Activity: Alcoholism - Management and Information (Public Health Service Act, Section 301).

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 169 | $ 8,053,000 | Indefinite | 80 | $ 7,011,000 |

Purpose: This subactivity supports the overall planning, direction, and coordination of the alcoholism programs supported by the NIAAA. Also included in 1976 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. Included also are the nationwide information collection and dissemination activities carried out by the National Clearinghouse for Alcohol Information, and State and local prevention and education programs developed by the National Center for Alcohol Education.

Accomplishments in 1976: Activities aimed at increasing the nation's awareness of the risks involved in heavy drinking continued to receive major emphasis. This was carried out through the National Clearinghouse for Alcohol Information which collects alcoholism literature from around the world and disseminates it to millions from all sectors of the population. The National Center for Alcohol Education continued to develop alcoholism education programs for local needs and provide in-house training for State alcoholism directors and policy makers.

Objectives for 1977: In 1977, the Institute will support the activities carried on by the National Clearinghouse for Alcohol Information and the National Center for Alcohol Education at reduced levels. The Institute will reduce the staff from 169 to 80 positions.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Buildings and Facilities

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | Authorization | Budget Estimate | |
| Pos. | Amount | | Pos. | Amount |
| --- | $13,558,000 | Indefinite | --- | --- |
| (B.A.) | (10,600,000) | | | |

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 1976: The funds remaining available from previous years' appropriations are being utilized for improvements and renovations at Saint Elizabeth's Hospital to help remedy accreditation deficiencies cited by the Joint Commission on the Accreditation of Hospitals (JCAH). These funds will be used to remedy major deficiencies in the areas of safety, patient privacy, service to patients, and air conditioning.

Of the $10.6 million in new obligational authority, $5.4 million will be used to correct deficiencies cited by the JCAH in its 1974 report. Of the amount $2.9 million will be used to develop architectural plans and drawings for patient space for 800 beds which is necessary to relieve overcrowding. The remaining funds will be used to improve patient safety, privacy and services.

A supplemental appropriation of $5.2 million will be proposed to correct deficiencies cited in the 1975 JCAH report. These funds will correct major fire safety deficiencies.

Objectives for 1977: A $75,000,000 buildings and facilities appropriation to regain accreditation of the Hospital will be included in a separate legislative proposal whose goal will be the eventual transfer of the Hospital to the District of Columbia.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Program Direction - Standard Level User Charges (Public Health Service Act, Section 301)

| 1976 Appropriation | | 1977 | | |
|---|---|---|---|---|
| | | Authorization | Budget Estimate | |
| Pos. | Amount | | Pos. | Amount |
| --- | $1,532,000 | Indefinte | --- | $2,550,000 |

Purpose: These funds provide for the rental payments to GSA for buildings occupied by regional office and headquarters staff.

Explanation: The Public Building Amendment of 1972 (P.L. 93-313) requires each agency occupying space assigned by GSA to reimburse them for space. In 1976, the Congress appropriated funds at the 1975 level for Program Direction. In doing so, a total of $1,532,000 was appropriated for rental charges. However the 1976 actual charges will be $2,265,000. This deficiency will be absorbed by the Institutes in FY 1976 since this line item includes funds for all of the Agency's buildings. The 1977 request is $2,550,000, an increase of $1,018,000 over the amount appropriated in FY 1976.

Accomplishments in 1976: Not applicable.

Objectives for 1977: Not applicable.

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ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Program Direction - Other expenses (Public Health Service Act, Section 301)

| 1976 Appropriation | | 1977 Authorization | 1977 Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | | Pos. | Amount |
| 354 | $9,831,000 | Indefinite | 338 | $10,678,000 |

Purpose: These funds provide support for the overall direction and management of the agency and the regional office 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.

Accomplishments in 1976: Particular emphasis in FY 1976 was given to CMHC's to increase third party payments, improve management, cost accounting and record keeping systems.

Objectives for 1977: 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. In addition, technical assistance efforts in the Regional Offices will assist the states in initiating, developing, and managing the new resources available to them under the proposed consolidated state health bloc program for Mental Health and Alcohol community services projects.

Allocation of Funds for Drug Abuse Formula Grants 1/

| State | 1976 Appropriation | 1977 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 |
| 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 |
| American Samoa | 6,253 | 6,253 |
| Guam | 19,525 | 19,525 |
| Mariana Islands | 20,115 | 20,115 |
| Puerto Rico | 596,413 | 596,413 |
| Virgin Islands | 15,356 | 15,356 |
| Total | $35,000,000 | $35,000,000 |

1/ FY 76 and 77 funds are allocated to states based on a formula which measures the relative population, financial and program need of each state.

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Allocation of Funds for Alcohol

| | Formula Grants | |
|---|---|---|
| | 1976 Appropriation | 1977 Estimate |
| Alabama | $ 1,085,850 | $ 883,930 |
| Alaska | 200,000 | 200,000 |
| Arizona | 566,373 | 461,052 |
| Arkansas | 633,060 | 515,338 |
| California | 4,923,628 | 4,008,070 |
| Colorado | 627,287 | 510,639 |
| Connecticut | 695,294 | 565,999 |
| Delaware | 200,000 | 200,000 |
| District of Columbia | 200,000 | 200,000 |
| Florida | 2,074,445 | 1,688,690 |
| Georgia | 1,353,533 | 1,101,835 |
| Hawaii | 200,000 | 200,000 |
| Idaho | 226,395 | 200,000 |
| Illinois | 2,573,966 | 2,095,322 |
| Indiana | 1,368,101 | 1,113,695 |
| Iowa | 730,919 | 595,000 |
| Kansas | 567,692 | 462,126 |
| Kentucky | 987,606 | 803,954 |
| Louisiana | 1,121,860 | 913,243 |
| Maine | 305,067 | 248,338 |
| Maryland | 971,608 | 790,931 |
| Massachusetts | 1,405,761 | 1,144,351 |
| Michigan | 2,168,016 | 1,764,861 |
| Minnesota | 1,000,471 | 814,427 |
| Mississippi | 755,548 | 615,049 |
| Missouri | 1,241,105 | 1,010,314 |
| Montana | 200,000 | 200,000 |
| Nebraska | 390,391 | 317,795 |
| Nevada | 200,000 | 200,000 |
| New Hampshire | 212,211 | 200,000 |
| New Jersey | 1,664,097 | 1,354,648 |
| New Mexico | 338,273 | 275,369 |
| New York | 4,154,608 | 3,382,035 |
| North Carolina | 1,517,529 | 1,235,335 |
| North Dakota | 200,000 | 200,000 |
| Ohio | 2,693,046 | 2,192,258 |
| Oklahoma | 761,376 | 619,793 |
| Oregon | 589,023 | 479,490 |
| Pennsylvania | 2,990,141 | 2,434,107 |
| Rhode Island | 238,710 | 200,000 |
| South Carolina | 842,797 | 686,073 |
| South Dakota | 200,000 | 200,000 |
| Tennessee | 1,200,642 | 977,375 |
| Texas | 3,260,078 | 2,653,848 |
| Utah | 339,428 | 276,309 |
| Vermont | 200,000 | 200,000 |
| Virginia | 1,268,648 | 1,032,735 |
| Washington | 867,536 | 706,212 |
| West Virginia | 530,308 | 431,693 |
| Wisconsin | 1,195,419 | 973,123 |
| Wyoming | 200,000 | 200,000 |
| Guam | 32,271 | 26,270 |
| Puerto Rico | 959,513 | 781,085 |
| Virgin Islands | 26,609 | 21,660 |
| American Somoa | 9,016 | 7,339 |
| Trust Territory | 34,745 | 28,284 |
| TOTAL | 55,500,000 | 45,600,000 |

Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Appropriation | Transition Quarter |
| General Mental Health | | |
| Research | $95,908,000 | $24,300,000 |
| Training | 85,100,000 | 3,100,000 |
| Community Programs | | |
| Cooperative Statistics | --- | --- |
| Construction | 14,250,000 | --- |
| Staffing | 135,363,000 | 17,360,000 |
| Child Mental Health | 26,844,000 | 5,000,000 |
| Operation of CMHC's | 53,500,000 | --- |
| Subtotal | 229,957,000 | 22,360,000 |
| Management and Information | 22,229,000 | 5,566,000 |
| Subtotal General Mental Health | 433,194,000 | 55,326,000 |
| Drug Abuse | | |
| Research | 34,000,000 | 3,575,000 |
| Training | 10,000,000 | 250,000 |
| Community Programs | | |
| Project Grants and Contracts | 139,051,000 | 14,590,000 |
| Grants to States | 35,000,000 | --- |
| Subtotal | 174,051,000 | 14,590,000 |
| Management and Information | 14,121,000 | 2,800,000 |
| Subtotal Drug Abuse | 232,172,000 | 21,215,000 |
| Alcoholism | | |
| Research | 11,504,000 | 3,600,000 |
| Training | 7,458,000 | 2,300,000 |
| Community Programs | | |
| Project Grants and Contracts | 56,408,000 | 10,940,000 |
| Grants to States | 55,500,000 | --- |
| Subtotal | 111,908,000 | 10,940,000 |
| Management and Information | 8,053,000 | 1,400,000 |
| Subtotal Alcoholism | 138,923,000 | 18,240,000 |
| Buildings and Facilities | 13,558,000 | --- |
| Program Direction | 11,363,000 | 2,613,000 |
| Total ADAMHA | 829,210,000 | 97,394,000 |

Explanation

The funds for the period July 1, 1976 through September 30, 1976 will provide: (1) new funds for the level of research awards normally made in this period; (2) limited new amounts in Drug Abuse community programs; and (3) normal continuation costs for all other programs except Alcohol and Mental Health community programs. Funds provided for new awards in 1976 will be used to meet continuation costs in the Transition Quarter in program areas for which Transition Quarter funds listed above are not sufficient.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

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# SAINT ELIZABETHS HOSPITAL

WEDNESDAY, MARCH 3, 1976.

## WITNESSES

DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH
JAMES E. PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
P. E. GOODY, BUDGET OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
DR. ROGER PEELE, ACTING SUPERINTENDENT, SAINT ELIZABETHS HOSPITAL
JAMES J. O'DONNELL, BUDGET OFFICER, SAINT ELIZABETHS HOSPITAL
EARL SHELLY, ACTING EXECUTIVE OFFICER, SAINT ELIZABETHS HOSPITAL
DR. LUTHER D. ROBINSON, ASSOCIATE SUPERINTENDENT OF PSYCHIATRY, SAINT ELIZABETHS HOSPITAL
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLOOD. We will now take Saint Elizabeths Hospital. We have a presentation to be made by Dr. Brown, who is the Director of the National Institute of Mental Health. Your biographical sketch, Doctor, will be inserted in the record at this point. We will insert the prepared statement you have, and then I will have some questions for you.

[The biographical sketch and the statement follow:]

CURRICULUM VITAE

Name: 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; 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, staff psychiatrist, Mental Health Study Center.

July 5, 1961 to October 14, 1963, special assistant for program, extramural programs.

October 15, 1963 to March 22, 1964, special assistant for program, office of the director.

March 23, 1964 to June 5, 1966, Chief, Community Mental Health Facilities Branch.

June 9, 1966 to December 31, 1966, associate director for mental health service programs.

January 1, 1967 to June 2, 1970, Deputy Director, National Institute of Mental Health.

June 3, 1970 to present, 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 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 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.

Miiltary 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; 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; American Medical Association.

Mr. Chairman and members of the committee, I am grateful for this opportunity to appear before you, and present the budget request for Saint Elizabeths Hospital.

As many of you kwow, several events have taken place which fundamentally affect the hospital, during a particular crucial phase of its existence. Among these events are the recent loss of accreditation; a significant group of legal decisions affecting both the rights and future course of treatment of nearly half of the inpatients at Saint Elizabeths; and our continuing efforts to see the hospital eventually become an integral part of the mental health care system of the District of Columbia.

Like many institutions today, Saint Elizabeths is obliged to deal with a variety of imperatives, many of which would appear to pull in opposite directions. We must improve the physical plant. We must increase the number of employees in critical areas. We must make every effort to place patients in treatment settings which offer the least restrictive alternative care. At the same time, we are charged with the task of developing a fiscally responsible, but humane plan for turning ultimate control of the hospital over to the District of Columbia. I am pleased to report that we have at least made a start at addressing these problem areas.

Our first priority is to restore the accrediation of Saint Elizabeths Hospital. This objective is basic to the rights of patients to receive the level of treatment to which they are legally entitled. It is also our intention to transfer a fully accredited facility to the District of Columbia. The tasks ahead of us fall into three broad categories.

The first relates to the improvement of internal management—primarily the development of more comprehensive documenation of patient records and hospital procedures. Work is well underway in this area and we expect early completion, with no requirement for additional funding.

The second need relates to facilities. In order to regain the hospital's accreditation, we must relieve overcrowding; make better provision for the privacy of patients; improve fire and safety precautions; and make more adeqate the facilities which provide services to patients. Several steps have already been taken in this direction. Last year we requested, and received, congressional approval to reprogram $1,260,000 in available facility improvement funds, in order to start work on the most urgent accreditation items. This year, Congress appropriated $5,400,000 to begin plans for the relief of overcrowding, and to address other physical plant problems identified in the 1974 JCAH survey. In addition, we have already submitted for your consideration a supplemental appropriation request for $5,200,000, to fund the fire and safety improvements deemed necessary under the most recent survey by the Joint Commission on Accreditation of Hospitals. The 1977 budget request includes $75 million to move ahead with construction and renovation work related to the relief of overcrowding. To make the best use of the money in terms of meeting needs of our patients, we must take into account the judicial requirements for placement of patients outside the hospital, and the availability of community resources. Hence, we would hope that there would be flexibility—not only for construction and renovation ,but also for leasing and acquisition. In this way, it would be possible to meet the needs of those Saint Elizabeths patients who are in community settings. This would clearly be in the best interests of the greatest number of patients.

The third and final area of need relates to staff. In the past two surveys, the Joint Commission on Accreditation of Hospitals has recommended more adequate staffing in a variety of fields, including nursing, housekeeping, pharmacy, and rehabilitation programs. We have already submitted a 1976 supplemental to restore prior losses of staff. The degree to which additional staff is required is currently under study by a management survey team, and solutions for the staffing problem will be proposed in the near future.

During this fiscal year, legislation will be submitted proposing to transfer Saint Elizabeths Hospital to the District of Columbia by a date which will be mutually agreed upon. Prior to the actual transfer, the Department and the District of Columbia will develop formal agreements for the transfer, along with delegations of authority and requests fro resources. The legislative proposal will also include funds for construction and renovation of hospital facilities.

The 1977 operating budget request for Saint Elizabeths Hospital totals $81,744,000, represnting an increase of $4,183,000 over the program anticipated for the current year. The additional amount provides for salary and cost-of-living increases, as well as restoration of hospital employment to a level comparable with that which existed at the time of the 1974 survey of the hospital by the Joint Commission on Accreditation of Hospitals. Of the $81,744,000 operating level proposed for 1977, $57,964,000 represents the estimated appropriation share, with the remainder to be derived from reimbursements.

During 1977, it is estimated that approximately 9,800 patients will be treated. The average daily patient load for 1977 is expected to total 5,700, of which 2,700 are expected to reside in the hospital.

I will be happy to answer any questions which the committee might have.

EFFECT OF DISACCREDITATION

Mr. FLOOD. Doctor, what effect does this loss of accreditiation at St. Elizabeths have in terms of your training program and your elegibility for third party reimbursements?

Dr. BROWN. If the disaccreditation stands, it will adversely affect our ability to attract both trainees and staff, and possibly jeopardize the ability of our trainees to obtain board certification in their various special fields. If the disaccreditation stands, it will also threaten our ability to receive medicare funds.

INTERNAL MANAGEMENT

Mr. FLOOD. In your statement you identify three areas requiring improvement, in order to regain accreditation for the hospital. One of these was improvement in the internal management. Will you explain in some detail what you are doing in that area?

Dr. BROWN. I think that is my first clue as quarterback to throw the football to Dr. Roger Peele, the Acting Superintendent of the hospital.

Dr. PEELE. Mr. Flood, the major management issue that the Joint Commission pointed out was in documentation of therapeutic efforts. There has been considerable improvement in terms of documentation within the medical records since the Joint Commission visited us in the second week of September.

Dr. BROWN. There were other items which came under the broad area of management improvements. These included the upgrading of disaster planning activities; improvement in the ability of the hospital to evaluate the quality of medical care; and greater attention to drug utilization.

Mr. FLOOD. You also said in your statement that you do not need now any additional funding for this area of improvement. Why is that?

This is your hot potato. I don't want you coming back here and saying "We asked Congress for money and they didn't give us any."

Dr. BROWN. This represents an area where we can effect improvements by tightening up our own procedures and reallocating existing resources. In other words, this is one of the times when we are saying mea culpa.

Mr. FLOOD. Mea maxima culpa. And today is Ash Wednesday, so don't forget.

Dr. BROWN. We don't want money.

Mr. FLOOD. You do it with your right hand, too. Don't forget that.

Dr. BROWN. I am sorry for the shock it caused not asking for funds for improving this area.

Mr. FLOOD. You also said you expect the completion of a more comprehensive documentation of the patients' records, also of the hospital procedures documentation. Well, by what date do you expect to have that completed?

Dr. PEELE. In many ways documentation has already been improved.

Dr. BROWN. The work is about 90 percent completed.

Mr. FLOOD. I know. But what date do you expect to have these both completed—the documentation and the procedures? What is your target?

Dr. PEELE. We would be willing to be surveyed on those items today.

Mr. FLOOD. All right.

FACILITIES

Have you spent any of that $5,400,000 that we expressly included for the facility improvements in the regular 1976 Appropriation bill?

Dr. BROWN. We have not spent that yet. We are at this time preparing the contracts and the other necessary preludes to spending the money well.

Mr. FLOOD. That won't do. I want to know when and how is that money going to be spent? We included that for this specific purpose in the 1976 bill. All right. I said did you spend any of it. "No; we didn't." All right—when and how? We have to have an answer to this one. This St. Elizabeths thing is red hot. We have to know how and when.

Dr. BROWN. We will provide a detailed document for the record.

Mr. FLOOD. I am sure of that.

Dr. BROWN. I think Mr. Miller can help me out again.

Mr. FLOOD. OK, Mr. Miller. When and how, within reason.

[The information follows:]

Insert page 3337 (a)

Saint Elizabeths Hospital

Summary of Facility Improvement Projects Funded from FY 1976 Appropriations

| | 1976 Appropriation | 1976 Proposed Supplemental | 1976 Total |
|---|---|---|---|
| Relief of overcrowding: | | | |
| Plans and specifications for construction and renovation of patient buildings | $2,900,000 | --- | $2,900,000 |
| Improvement of safety: | | | |
| 1. Emergency lighting | --- | $50,000 | 50,000 |
| 2. Fire detection & alarm system | 1,420,000 | --- | 1,420,000 |
| 3. Construct fire doors | --- | 350,000 | 350,000 |
| 4. Fireproof corridor doors | --- | 1,200,000 | 1,200,000 |
| 5. Install fixed wire glass windows | --- | 50,000 | 50,000 |
| 6. Install firestops & separations | --- | 500,000 | 500,000 |
| 7. Enclose stairwells | --- | 750,000 | 750,000 |
| 8. Install exit signs | --- | 12,000 | 12,000 |
| 9. Improve exits in buildings | --- | 700,000 | 700,000 |
| 10. Special exits for handicapped | --- | 950,000 | 950,000 |
| 11. Improve wiring | --- | 588,000 | 588,000 |
| 12. Protect transoms | --- | 50,000 | 50,000 |
| Subtotal | 1,420,000 | 5,200,000 | 6,620,000 |
| Improvement of patient privacy: | | | |
| 1. Improve patient areas | 545,000 | --- | 545,000 |
| 2. Closet & drawer equipment | 235,000 | --- | 235,000 |
| Subtotal | 780,000 | --- | 780,000 |
| Improve service for patients: | | | |
| 1. Nursing station modifications | 220,000 | --- | 220,000 |
| 2. Laundry rooms & equipment | 55,000 | --- | 55,000 |
| 3. Improve pharmacy | 25,000 | --- | 25,000 |
| Subtotal | 300,000 | --- | 300,000 |
| Total | 5,400,000 | 5,200,000 | 10,600,000 |

NOTES

Funds for plans and specifications leading to construction and renovation of patient buildings will be obligated upon completion of a separately funded planning study currently being negotiated. The purpose of the planning study is to develop recommendations for resolution of such issues as renovation versus new construction; consistency with District of Columbia Mental Health program plans; and optimum physical location. Planning funds related to actual construction and/or renovation which will provide adequate patient space to meet JCAH requirements should be obligated early in FY 1977.

Contracts are already being developed for work relating to improvement of safety, privacy and patient services. Actual work for approximately half of these projects is expected to be underway prior to 6/30/76. The remaining projects will be started early in FY 1977. All work is expected to be completed by 9/30/77.

Mr. MILLER. Mr. Chairman, this was not one of the items recommended for rescission. I think we received the apportionments from OMB last week. They are probably just reaching NIMH now.

TRANSFER OF ST. ELIZABETHS

Mr. FLOOD. You also mentioned in your statement that you were now negotiating with the District of Columbia for the transfer of the hospital by a mutually agreed date. How is that negotiation getting along?

Dr. BROWN. The negotiation is active. There have been three meetings already between Mr. Dugas and Mr. Yeldell, designated by Mayor Washington, and by myself and my staff, designated by Secretary Matthews. We have another meeting scheduled this week. We are dealing with the full range of issues including accreditation, transfer, and the Robinson decision. Specifically, OMB has under preparation the legislative proposal which will include a specific date.

Mr. FLOOD. All those things being true, when do you expect to submit a legislative proposal to the Congress for the transfer of St. Elizabeths Hospital?

Dr. BROWN. Our target date is April 1.

CONSTRUCTION FUNDS

Mr. FLOOD. All right.

If the estimates by the Department were that it would take $75 million to put St. Elizabeths Hospital back in shape, or at least to comply with the recommendations of the Joint Commission on Accreditation of Hospitals, why do you want to wait for the transfer? Why don't you do it now? Why delay it? Why wait?

Dr. BROWN. That $75 million will be in the legislation submitted to the Congress as a special budget item that will be formally submitted in the legislative process.

We are underway in our planning for how to best use those funds right now, though of course it awaits formal submission to the Congress and then approval by the Congress. The important thing is that we work closely with the District in planning for the use of these funds. We don't want to move ahead until we are sure that the District's mental health program planning needs are addressed. Again, may I turn to Mr. Miller?

Mr. MILLER. I have nothing to add. It is supposed to be associated with a plan that is developed between the District of Columbia and us, and to be sent up at the time we have a formal plan to submit to the Congress. And it is not proposed that you act on it before that.

Mr. FLOOD. All right.

STAFFING

By the way, Doctor—the other area you talked about in your statement was staffing. When do you expect to complete that manpower study? We would like a copy of that report as soon as it is completed.

Dr. BROWN. We have the manpower study nearly completed.

Mr. FLOOD. When?

Dr. BROWN. It will be done June 16. We will be happy to furnish a copy when it is completed.

Mr. FLOOD. All right.

When you testified on the supplemental appropriation, we discussed a need for an additional 175 positions over the 104 that you asked for. Do you think that is still a good figure, or do you want to revise that?

Dr. BROWN. I'm confident of the figure and I am hopeful of favorable consideration by my superiors.

Mr. FLOOD. Were you in the Marine Corps by any chance?

Dr. BROWN. The Air Force, Mr. Flood.

Mr. FLOOD. All right, suppose you insert for the record the report that you submitted to the committee, outlining that need for the 175 additional jobs.

[The information follows:]

SAINT ELIZABETHS HOSPITAL
Analysis of Additional Staffing Requirements
In Response to 1974 Recommendations of the Joint Commission on Accreditation of Hospitals (JCAH)

## Background

The 1974 survey of Saint Elizabeths by JCAH cited several areas in which the Hospital needed additional activity and staff. A manpower survey team comprised of Saint Elizabeths Hospital management specialists undertook an analytic effort to determine specific manpower needs, in number and distribution, based on accepted standards and workload requirements. In several manpower categories, i.e., activity therapy, pharmaceutical service delivery, and housekeeping, statistical analyses have been carried out to determine manpower needs.

In the area of health care delivery manpower (nurses, nursing assistants, physicians, and mental health professional categories) potential analytic techniques are under study which will allow for more accurate workload forecasts and staffing arrangements. As of this date, manpower requests in this area are based on the best estimates of senior management staff at Saint Elizabeths Hospital and the National Institute of Mental Health.

The following tables display the need for 175 additional staff in the categories mentioned above. Table I includes an analysis of four operational areas (Occupational Therapy, Recreational Therapy, Pharmacy, and Housekeeping); a breakdown of each; and a determination of required man-years based on expected work volume. Table II is a composite of position requests for the Hospital including clinical area needs.

## Definitions

1. Volume in Units (X) - refers to the number of units or times each activity in the left hand column was carried out during the base year.

2. Man-Hours (Y) - refers to the man-hours needed to carry out the activities in the left hand column during the base year.

3. Standard (Y/X) - indicates the average time needed to perform an individual activity unit (computed by dividing the man-hours spent in each activity by the number of times the activity was carried out).

4. Man-Hours (Y/2000) - are calculated by dividing the man-hours by 2000. (2000 hours is approximate time worked by an individual in a full year.)

5. Expected Volume in Units (Z) - refers to the number of units or times each activity is expected to be carried out in the current fiscal year.

6. Required Man-Hours (Y/X(Z)) - refers to the man-hours needed to carry out the activities in the current year. (Calculated by multiplying the standard (Y/X) by the expected volume (Z)).

7. Required Man-Years - is calculated by dividing the required man-hours by 2000.

Insert Page 3341 (b)

Table I - Analysis of Major Occupational Areas

Part A - Base Year Data

| Operations | Volume in Units X | Man-Hours Y | Standard Y/X | Man-Years Y/2000 |
|---|---|---|---|---|
| 1. Occupational Therapy: | | | | |
| Arts and Crafts..... | 6864 | 13,728 | 2.0 | 6.8 |
| Activities of Daily living | 3224 | 4,160 | 1.3 | 2.1 |
| Woodworking | 884 | 1,768 | 2.0 | .9 |
| Sewing | 936 | 936 | 1.0 | .5 |
| Testing and Evaluation | 1768 | 3,536 | 2.0 | 1.8 |
| Instruction of patients | 1456 | 2,912 | 2.0 | 1.4 |
| Interview/Work Placement | 3328 | 3,328 | 1.0 | 1.7 |
| Documentation | A/ | 13,600 | A/ | 6.8 |
| Administration | A/ | 19,000 | A/ | 9.5 |
| Training | A/ | 15,000 | A/ | 7.5 |
| TOTAL MAN-YEARS (OT)..... | | | | 39.0 |
| 2. Recreational Therapy: | | | | |
| Crafts | 4472 | 5,824 | 1.3 | 2.9 |
| Musical Activities | 1248 | 1,872 | 1.5 | .9 |
| Sports Activities | 1560 | 1,872 | 1.2 | .9 |
| Social Activities | 1560 | 3,120 | 2.0 | 1.6 |
| Art Therapy | 572 | 1,144 | 2.0 | .6 |
| Community Trips | 416 | 1,248 | 3.0 | .6 |
| Documentation | A/ | 7,000 | A/ | 3.5 |
| Administration | A/ | 14,000 | A/ | 7.0 |
| Training | A/ | 6,000 | A/ | 3.0 |
| TOTAL MAN-YEARS (RT)..... | | | | 21.0 |
| 3. Pharmacy: | | | | |
| Filing Prescriptions and Drug Requisitions | 86,323 | 10,425 | .120 | 5.2 |
| Ordering, Receiving, Storage | 5,568 | 8,630 | 1.54 | 4.3 |
| Repackaging and Manufacturing | 74,880 | 3,744 | .05 | 1.8 |
| Review of Medicine Stations | (Not performed during base year) | | | |
| IV Admixtures Program | (Not performed during base year) | | | |
| Adminstrative | N/A | 5,400 | N/A | 2.7 |
| Training | N/A | | N/A | |
| TOTAL MAN-YEAR (Pharmacy)..... | | | | 14.0 |
| 4. Housekeeping: | | | | |
| General Housekeeping | 1,630,000 | 362,000 | .222 | 181.0 |
| Administrative | N/A | 60,000 | N/A | 30.0 |
| TOTAL MAN-YEARS (Housekeeping)..... | | | | 211.0 |

A/ Volume in units cannot be measured. Man-hours represent estimates.

B/ Volume in units represents square feet of space to be cleaned. The American Hospital Association has established a standard of 8,000 square feet per housekeeper in health delivery areas. A standard of 14,500 square feet per housekeeper is estimated for administrative areas.

Insert Page 3341 (c)

Table II - Part B - Current Year Estimates

| OPERATION | Expected Volume in Units Z | Required Man-Hours $\frac{Y}{X}$ (Z) | Required Man-Years |
|---|---|---|---|
| 1. Occupational Therapy: | | | |
| Arts and Crafts | 11,000 | 22,000 | 11.0 |
| Activities of Daily Living | 6,000 | 7,800 | 3.9 |
| Woodworking | 1,200 | 2,400 | 1.2 |
| Sewing | 1,350 | 1,350 | .7 |
| Testing & Evaluation | 3,000 | 6,000 | 3.0 |
| Instruction of Patients | 2,500 | 5,000 | 2.5 |
| Interview/Work Placement | 5,600 | 5,600 | 2.8 |
| Documentation | A/ | 16,000 | 8.0 |
| Administration | A/ | 25,000 | 12.5 |
| Training | A/ | 18,600 | 9.2 |
| TOTAL MAN-YEARS (OT) | | | 54.8 |
| 2. Recreational Therapy: | | | |
| Crafts | 13,000 | 16,800 | 8.4 |
| Muscial Activities | 3,600 | 5,400 | 2.7 |
| Sports Activities | 6,000 | 7,200 | 3.6 |
| Social Activities | 3,000 | 4,800 | 2.4 |
| Art Therapy | 1,900 | 3,800 | 1.9 |
| Community Trips | 800 | 2,400 | 1.2 |
| Documentation | A/ | 12,000 | 6.0 |
| Administration | A/ | 22,000 | 11.0 |
| Training | A/ | 12,000 | 6.0 |
| TOTAL MAN-YEARS (RT) | | | 43.2 |
| 3. Pharmacy: | | | |
| Filing Prescriptions and Drug Requisitions | 99,275 | 11,913 | 5.9 |
| Ordering, Receiving, Storage | 6,626 | 10,005 | 5.0 |
| Repackaging and Manufacturing | 74,880 | 3,744 | 1.8 |
| Review of Medicine Stations | 1,272 | 521 | .3 |
| IV Admixtures Program | 15,600 | 3,120 | 1.5 |
| Administrative | N/A | 5,600 | 2.8 |
| Training | N/A | 1,400 | .7 |
| TOTAL MAN-YEARS (Pharmacy) | | | 18.0 |
| 4. Housekeeping: | | | |
| General Housekeeping B/ | 2,189,111 | 485,982 | 243.0 |
| Administrative | N/A | 70,000 | 35.0 |
| TOTAL MAN-YEARS (Housekeeping) | | | 278.0 |

A/ Volume in units cannot be measured. Man-hours represent estimates.
B/ Volume in units represents square feet of space to be cleaned. The American Hospital Association has established a standard of 8,000 square feet per housekeeper in health delivery areas. A standard of 14,500 square feet per housekeeper is estimated for administrative areas.

Insert Page 3341 (d)

TABLE II

POSITION REQUEST SUMMARY

| OPERATION | BASE (1974) | REQUEST | CHANGE |
|---|---|---|---|
| Occupational therapy | 39.0 | 54.8 | + 15.8 |
| Recreational therapy | 21.0 | 43.2 | + 22.2 |
| Pharmacy | 14.0 | 18.0 | + 4.0 |
| Housekeeping | 211.0 | 278.0 | + 67.0 |
| | 285.0 | 394.0 | +109.0 |
| Nurses & Nursing Assts. | 1858.0 | 1898.0 | + 40.0 |
| Physicians (Gen.) | 48.0 | 54.0 | + 6.0 |
| MH Professionals (Psychiatrists, Psychologists, Social Workers) | 145.0 | 165.0 | + 20.0 |
| | (2051.0) | (2117.0) | (+ 66.0) |
| TOTAL..... | 2336.0 | 2511.0 | +175.0 |

Do you believe that the hospital accreditation will be restored, provisionally restored, now that the resources are being made available? What do you think?

Dr. BROWN. Yes.

Mr. FLOOD. All right.

Mr. Patten?

Mr. PATTEN. Well, I join with the chairman—I usually read about St. Elizabeths, that some patient went out for the weekend and came back with a gun and shot somebody. You don't have anything to do with St. Elizabeths, do you?

Dr. BROWN. We are the next layer up.

Dr. Peele is the Acting Superintendent of the hospital, which has been under NIMH since 1967.

Mr. PATTEN. It looks like it costs about $200 a day out there per patient. You said you had 5,700—talking about some $80 millions.

It looks like, per capita, close to 200 bucks a day. Is that comparable with around the country?

Dr. BROWN. It comes out to about $75 a day, which puts it about fifth down out of the 50 States, if you compare it with other States. In other words, it is better than most, but not as good as some, when you compare it with other State institutions by money costs.

Mr. PATTEN. You said earlier that we have cut in half the number of people in institutions around the country, due to one thing or another. Does that apply to St. Elizabeths?

Dr. BROWN. In 1967, when we took St. Elizabeths under our direct wing, there were 5,660 in-patients, Mr. Patten. There are 2,725 now, some 7 years later. So, we have been able to replicate the national experience right here with St. Elizabeths.

### SEH ACCREDITATION AND TRANSFER

Mr. FLOOD. Mr. Michel.

Mr. MICHEL. When do you expect to bring the hospital to a point where accreditation can again be expected?

Dr. BROWN. We are hopeful that the Congress will approve the administration's request for funds to correct the various deficiencies identified by the Commission so that the hospital can be reaccredited. As soon as we have word that the Congress has approved the administration's request for the $5.2 million fiscal year 1976 supplemental, we will request the Joint Commission to make a reevaluation of the hospital. I am sure that the Commission will honor the request and in light of the commitment by the Federal Government to correct the identified deficiencies, there is a possibility that they will reaccredit the hospital for 1 year in 1976, at the end of which time the Commission will again evaluate the hospital and it accomplishments. If corrections can start in fiscal 1976, we are hopeful for a full 2-year accreditation by 1979.

Mr. MICHEL. What specific construction and renovation will be included in the $75 million proposal?

Dr. BROWN. The exact composition of the $75 million proposal will not be known until after completion of a planning study, and consultation with the District of Columbia. Tentatively, it consists of $46.6

million for construction and renovation of adequate bed space for approximately 800 patients, and the balance of $28.4 million is for badly needed repairs and improvements to patient care facilities and to the hospital's utility systems.

Mr. MICHEL. What is the likely timetable for turning the hospital over to the District?

Dr. BROWN. The District and HEW are presently working on a memorandum of agreement of transfer which will include a transfer date. While there has not been an agreement on a specific date, it is anticipated that it would be sometime in 1979 or 1980.

Mr. MICHEL. Is the District willing to receive it?

Dr. BROWN. The District and HEW have established a working committee which has had several meetings to discuss the various issues relating to transfer. A definite answer as to whether the District would be willing to receive the Hospital on transfer is directly related to the success of the discussions between the District and HEW, both at these meetings and at higher levels in attempting to resolve resulting differences.

Mr. MICHEL. What is the cost to the Federal Government likely to be for the transfer?

Dr. BROWN. A lot depends on the type of legislative package that is finally developed. To give you some idea of relative cost under a transfer, as opposed to a nontransfer situation, let's use the last legislative proposal as a model. Under the transfer bill submitted in July of 1973, a 10-year phased subsidy would have continued approximately the same level of Federal support for the 5 years after transfer, and scaled it down, on a straight line basis, to zero in the 11th year. Fitting this model to the 1977 budget, the total subsidy for the transitional period would come to approximately $441 million. Under continued Federal control, the subsidy for the same 10-year period would total $648 million.

Mr. MICHEL. Is a continuing annual Federal subsidy to the hospital likely after the transfer, and if so, will it be more or less than at present?

Dr. BROWN. Yes, it is likely. Its size and duration will have to be worked out and submitted as part of the upcoming legislative package. During the first few years after transfer, we expect the subsidy will either be equal to, or less than, the present level. Later, the level would drop off sharply, and probably reach zero at a point determined in the legislation.

SEH PATIENT CARE

Mr. MICHEL. What are the judicial requirements for placement of patients outside the hospital, which you refer to in your statement?

Dr. BROWN. The court order states that "the 1964 Hospitalization of the Mentally Ill Act requires that patients confined in St. Elizabeths Hospital pursuant to the 1964 act receive suitable care and treatment under the least restrictive conditions as such conditions are required in an individual case consistent with the purposes of the act; that the District of Columbia and the Federal Government defendants have a

joint duty to provide such care and treatment where appropriate; that both defendants have violated the 1964 act by failing to place plaintiffs and members of their class, who are inpatients at St. Elizabeths Hospital and who have been determined suitable for placement in alternative facilities and are less restrictive alternatives to the hospital, as it is presently constituted, such alternatives including but not being limited to nursing homes, foster homes. personal care homes, and halfway houses; and that, therefore, such failure is unlawful and invalid; and it is further ordered that 45 days from the date of this order, December 23, 1976; pursuant to a joint request by HEW and the District, the Court has extended an additional 45 days to March 22, the defendants shall submit to the Court an outline of a plan which shall detail the manner in which and the timetable by which defendants will meet their duty to provide plaintiffs who are and who will be inpatients at the hospital with care and treatment in suitable residential facilities under the least restrictive conditions consistent with the purpose of the 1964 act."

Mr. CONTE. What would be included under the unitization of services for patients?

Dr. BROWN. The unit system is an organizational concept which divides a large institution into several smaller, semiautonomous miniature hospitals. In a unitized system, a patient works with the same treatment team from the time he is first admitted until he is discharged from the outpatient rolls. A decentralized unit system is more expensive to run, but there are two major advantages. First, the patient receives more individualized care from a team of professionals who are thoroughly familiar with his case. Second, specific individuals can be held accountable for the success or failure of their treatment efforts. This was previously difficult—if not impossible—in a large institution organized according to professional discipline.

Mr. CONTE. Under the heading of "Efforts To Provide Better Services to Its Patients" on page 87 of the justification you list providing year-round training to local medical students. How will this help the patients?

Dr. BROWN. For many years, local medical students have received instruction in basic clinical psychiatry at St. Elizabeths. For the students, this promotes an understanding of mental health problems, regardless of their future specialty. For the hospital, these programs enhance patient care in several ways.

First, medical student instruction provides a source of personnel who enter the hospital's postgraduate training programs and staff positions. This applies both to psychiatric and nonpsychiatric medical specialties.

Second, the training program provides the opportunity to engage in clinical teaching activities with students. This is an important professional incentive in recruiting and retaining medical staff of high quality.

Third, the overall quality of care is enhanced by a situation in which students, under close staff supervision, assist in delivering direct medical services to patients.

Mr. CONTE. What is the average length of hospitalization? Has this changed since last year?

Dr. BROWN. The most recent data available is for 1975. In 1975, the median time since admission for patients on the rolls at the end of the year was 4.8 years. In 1974, the comparable figure was 4.3 years.

Mr. CONTE. How large of a mental health professional training program do you expect to have over the next few years?

Dr. BROWN. We expect to train approximately 92 interns and residents next year, including 20 in the field of psychiatry, 15 psychologists, 21 chaplains, 10 psychodramatists, 5 dentists, 12 in the area of occupational and recreational therapy, and 9 in other assorted disciplines. If you include the broader scope of training for mental health professionals, counselors, technicians and community groups, the program will reach approximately 5,500 people. We expect the size of this program to remain relatively stable over the next few years.

SEH ACCREDITATION AND TRANSFER

Mr. CONTE. Will the accreditation problem substantially delay transfer of St. Elizabeths Hospital to the District of Columbia?

Dr. BROWN. No. The accreditation problem should not delay the transfer if the hospital can receive the funds requested by the administration to initiate correction of the deficiencies as soon as possible. However, correction of all deficiencies that contributed to disaccreditation should be well along the way to full correction before transfer takes place.

SEH RESEARCH EFFORT

Mr. CONTE. How extensive is your research effort? Does it duplicate anything at ADAMHA?

Dr. BROWN. The St. Elizabeths research effort presently consists of three components, including nursing research; hospital and community studies; and behavior analysis and therapy. In addition there is a section on criminal behavior currently under the direct supervision of the acting superintendent. The research program at St. Elizabeths spent $459,000 in 1975. In 1976 and 1977, the budget will be roughly the same, except for coverage of inflationary increases. There are no duplications of ADAMHA programs. Projects undertaken at the hospital are selected on the basis of their appropriateness to the special characteristics of the varied patient population.

SEH ACCREDITATION

Mr. ROYBAL. You indicate you are trying to remedy three problems to regain accreditation for St. Elizabeths. First, you indicate there must be more comprehensive documentation of patient records and hospital procedures. What is the problem with the way you are presently keeping the records?

Dr. BROWN. The Accreditation Commission site visit of 1973 was critical of the manner in which the patient records at the hospital were kept, citing the lack of specific recordings by every member of the team involved in carrying out the patient's treatment plan. Although

the psychiatrist in charge of the patient's treatment program, the nurse, and frequently the social worker would document their findings and comments in the patient's chart, members of the team providing additional patient care activities such as patient education, patient recreation, and vocational rehabilitation frequently did not document their findings and comments in the patient's treatment record, but each recorded the patient's progress in their special activity records. Work on the part of hospital staff to correct these deficiencies resulted in the 1974 site visit team complimenting the hospital on its accomplishments. The 1975 survey team conducted a much more thorough survey and found medical records that did not have comments and reports of all of the team responsible for carrying out the patient treatment plan.

Mr. ROYBAL. What is the problem with current hospital procedures?

Dr. BROWN. The major problem with current hospital procedures is in the area of documenting all aspects of patient care and treatment in the official patient record by all members of the team involved in caring for the patient. In addition, the Commission criticized the hospital's medical staff bylaws as not sufficiently delineating the clinical privileges of both medical and nonmedical professionals or sufficiently clarifying the responsibilities of physicians in relation to nonmedical professionals. In its review of the minutes of the various professional staff meetings and committee meetings at the hospital, the Commission required that other mental health professionals in addition to physicians should also participate in medical staff and advisory committee meetings.

Mr. ROYBAL. In each case, how do you propose to remedy the problem?

Dr. BROWN. The hospital has already made many of the corrections identified by the Commission and we expect the documentation problem to be under control by continuing to work with the various health disciplines at the hospital in the full utilization of a single record system.

Mr. ROYBAL. Secondly, explain the problem relating to: overcrowding privacy of patients, fire and safety precautions, and adequate facilities. How were these conditions allowed to occur?

Dr. BROWN. Over a period of several years, patients requiring mental health care have been hospitalized at St. Elizabeths where they have been provided with the most modern type of psychiatric care and treatment available, with the ultimate goal being to return each patient to an active life in his community. Patients who were not amenable to being rehabilitated to full community life were, whenever possible, placed in less restrictive facilities in the community. Over these many years we have had great difficulty in locating suitable less restrictive community facilities for patients resulting in more and more of these patients staying in the hospital. Our inability to move patients back to the community, combined with continuous admissions of patients to the hospital created a perpetual overcrowding. Because of the critical nature of the overcrowding, both the hospital and the District have intensified their efforts to find community facilities and have reduced the patient load from 4,504 in 1970 to 2,700 today. However, except for an occasional bed becoming available in a less restrictive community facility, there are no additional

resources presently available in the community to take additional patients.

The lack of patient privacy is a direct result of the degree of overcrowding at the hospital. At present, 26 buildings on the hospital campus are being utilized to provide care for 2,695 inpatients. These buildings were constructed to provide optimum patient care that was in vogue at the time of construction resulting in rather extensive open areas with high ceilings and devoid of separating walls or partitions. As overcrowding continued, more beds were crowded into the open ward, resulting in decreasing individual privacy for patients along with less space for individual drawer space and other individual comfort furnishings.

The Commission considers the deficiencies in fire and safety at the hospital as being equal in importance to overcrowding and facility deficiencies in making its decision to disaccredit the hospital. The Commission cited numerous deficiencies in this area. I will indicate a selected number in order to give you an idea of the magnitude; lack of an autonomous emergency power source to provide necessary lighting for the safety of patients and personnel, lack of an electrically supervised, manually operated fire alarm system in all buildings, the need for 2-hour fire resistive construction and approved automatic fire extinguisher systems in severe hazardous areas, insufficient number of fire doors to conform to National Fire Protection Association standards, all facilities housing nonambulatory patients above ground level should have at least one elevator that will accommodate at least one adult-size bed. The Commission was critical of the manner in which soiled linen was collected and indicated that in some instances there was a possibility that the soiled linen could contaminate the environment.

Adequacy of facilities relates to both the physical condition of the buildings, the availability of modern fire and safety equipment, modern accommodations for patient care and adequate space to provide for adequate patient privacy. The Joint Commission has determined that the hospital is not in compliance with the Commission's standards in any of these areas.

Mr. ROYBAL. How were these conditions allowed to occur?

Dr. BROWN. Although the issue of transferring St. Elizabeths Hospital to the District of Columbia is over a hundred years old, it entered a period of most active consideration in 1963. This marked the point at which transfer began to have the effect of deferring as much as possible until after St. Elizabeths had left the Federal community. With few exceptions, each annual budget from 1963 to the present assumed that transfer would take place either in the budget war or shortly thereafter. Some renovation funds were allowed; however, the administration policy was that there would be no new major construction and that renovations and improvements would be strictly limited.

As a result of the deferral policy, there has been a steady deterioration of the physical plant; an increased strain on the ability of the staff to maintain the quality of service, with visible signs of general deterioration such as the loss of accreditation; employee unrest and periodic financial crisis; and increased numbers of legal actions against the hospital brought on behalf of patients.

Mr. ROYBAL. Did you or your predecessor come before this committee and tell us of these things?

Dr. BROWN. Yes. For several years our testimony has referred to the overcrowding and related facility problems developing at the hospital.

Mr. ROYBAL. In each case, how do you plan to remedy the situation?

Dr. BROWN. We are already well along the way in correcting the problems of documentation and in the area of hospital procedure. We plan to begin a reconstruction and modernization program to reduce overcrowding and provide for both patient safety and patient privacy. The funds requested by the administration to overcome these deficiencies identified by the Commission, if allowed by the Congress, would permit us to initiate a reconstruction and remodeling program at the hospital which would put the hospital in compliance with the Commission's standards so that it could again receive full accreditation.

Mr. ROYBAL. The third area is staff. You indicate that you have lost staff in the past. How many staff have you lost?

Dr. BROWN. Two years ago, the hospital was authorized 4,132 positions. Shortly after the 1974 survey by the Joint Commission on Accreditation of Hospitals, it lost 104 positions as the result of Departmentwide employment cutbacks. The positions have since been restored, and we are now in the process of recruiting for them.

Mr. ROYBAL. In what areas did you lose them?

Dr. BROWN. Across a wide array of specialties. About 26 of them were nursing assistants; another 20 were housekeeping aides; 12 were security staff; 14 were in the mental health professions of psychiatry, psychology, social work, and nursing, 5 were special rehabilitation staff in the fields of occupational, recreational, and alcohol rehabilitation, 8 were technicians in various medical and mental health fields, and the remaining 19 were maintenance and support staff.

Mr. ROYBAL. Why did you lose them?

Dr. BROWN. They were lost as the result of the employment cutback I mentioned earlier. I might mention that nobody was terminated. We cut back simply by not filling vacancies.

Mr. ROYBAL. How did this affect the operation of the hospital?

Dr. BROWN. The cuts contributed, at least in part, to the loss of accreditation. At a more specific level, the cuts manifested themselves in the form of less treatment time per patient; less attention to the maintenance of patients' records; less attention to maintenance of the physical plant; and a general increase in the use of overtime.

Mr. ROYBAL. How will you recruit new staff?

Dr. BROWN. We have already started. Through advertisements, referrals, and walk-in inquiries, we anticipate relatively little difficulty in this area.

Mr. ROYBAL. How many will you be recruiting?

Dr. BROWN. We will be hiring for the restored 104 positions we have just been discussing, plus another 149 vacancies from previously authorized positions, or a total of 253. Incidentally, over a quarter of these recruitments have already reached the stage of having firm commitments against them, or at least are in the process of active interview of applicants.

Mr. ROYBAL. If we give you the full appropriation, when can we expect the hospital to reach a level so that it can apply for accreditation?

Dr. BROWN. I cannot predict the actions of the JCAH, but we would at least be in a position to apply if we get favorable congressional action on our $5.2 million fiscal year 1976 supplemental request.

Mr. ROYBAL. Will we turn over to the District of Columbia a hospital that has accreditation?

Dr. BROWN. It is one of our primary objectives to transfer a fully accredited facility.

Mr. FLOOD. All right.

Thank you very much, Doctor.

Dr. BROWN. Thank you very much, Mr. Flood.

[The justifications follow:]

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, [$48,064,000] *$57,964,000* 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 [$75,186,000] *$81,744,000*.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

Amounts Available for Obligation

| | 1976 Appropriation | 1977 Estimate |
|---|---|---|
| Appropriation | $53,375,000 | $57,964,000 |
| Proposed supplemental | 2,000,000 | --- |
| Receipts and reimbursements from: | | |
| Federal funds | 919,000 | 1,049,000 |
| Trust funds | 300,000 | 300,000 |
| Non-Federal sources | 20,967,000 | 22,431,000 |
| Total, Obligations | 77,561,000 | 81,744,000 |

## Summary of Changes

| | |
|---|---|
| 1976 Estimated obligations | $77,561,000 |
| 1977 Estimated obligations | 81,744,000 |
| Net Change | +4,183,000 |

| | 1976 Base Pos. | 1976 Base Amount | Change From Base Pos. | Change From Base Amount |
|---|---|---|---|---|
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Average salary and wage grade adjustments and FY 1976 pay raise | 4,028 | $66,016,000 | --- | +$2,548,000 |
| 2. Cost of living increases for food and medical supplies, utilities, equipment and contractual services | --- | 11,170,000 | --- | +764,000 |
| 3. Annualization of FY 1976 employment increase | 104 | 375,000 | --- | +1,081,000 |
| Total increases | | | --- | +4,393,000 |
| Decreases: | | | | |
| A. Built-in: | | | | |
| 1. Reduction of one extra day in 1977 | --- | --- | --- | -210,000 |
| Net Change | | | --- | +4,183,000 |

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Obligations by Activity

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Clinical and Community Services.. | 4,132 | $77,561,000 | 4,132 | $81,744,000 | --- | +$4,183,000 |

Obligations by Object

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Total number of permanent positions | 4,132 | 4,132 | --- |
| Full-time equivalent of all other positions | 132 | 132 | --- |
| Average number of all employees | 4,182 | 4,257 | +75 |
| Personnel compensation: | | | |
| Permanent positions | $52,379,000 | $55,007,000 | +$2,628,000 |
| Positions other than permanent | 2,584,000 | 2,808,000 | +224,000 |
| Other personnel compensation | 3,456,000 | 3,602,000 | +146,000 |
| Special personal service payments | 885,000 | 885,000 | --- |
| Subtotal, personnel compensation | 59,304,000 | 62,302,000 | +2,998,000 |
| Personnel benefits | 5,365,000 | 5,786,000 | +421,000 |
| Travel and transportation of persons | 299,000 | 312,000 | +13,000 |
| Transportation of things | 86,000 | 91,000 | +5,000 |
| Rent, communications and utilities | 1,384,000 | 1,460,000 | +76,000 |
| Printing and reproduction | 56,000 | 56,000 | --- |
| Other services | 2,124,000 | 2,124,000 | --- |
| Supplies and materials | 7,437,000 | 8,107,000 | +670,000 |
| Equipment | 1,307,000 | 1,307,000 | --- |
| Lands and structures | 227,000 | 227,000 | --- |
| Claims and indemnities | 4,000 | 4,000 | --- |
| Subtotal | 77,593,000 | 81,776,000 | +4,183,000 |
| Deduct charges for quarters | -32,000 | -32,000 | --- |
| Total obligations by object | 77,561,000 | 81,744,000 | +4,183,000 |

SIGNIFICANT ITEMS IN HOUSE AND SENATE

APPROPRIATIONS COMMITTEE REPORTS

| Item | Action taken or to be taken |
|---|---|
| 1976 House/Senate Report | |
| 1. The House and Senate directed that 104 budgeted positions and related ceilings proposed for removal from the Hospital's permanent employment be restored in 1976. | 1. The ceilings have been restored, and funds for their support included in the budget request. |
| 2. The House and Senate directed that the Department submit a report, outlining plans for fully complying with the recommendations of the Joint Commission on Accreditation of Hospitals. | 2. The report has been submitted. |

SAINT ELIZABETHS HOSPITAL

| Year | Budget Estimate To Congress | House Allowance | Senate Allowance | Appropriation 1/ |
|---|---|---|---|---|
| 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 | 47,617,000 | 47,617,000 | 47,617,000 | 49,673,000 |
| 1976 | 48,064,000 | 48,064,000 | 48,064,000 | 53,375,000 |
| 1976 Supp. | 2,000,000 | | | |
| 1977 | 57,964,000 | | | |

1/ Differences between appropriation amounts and House and Senate allowances are partially due to changes in estimated patient load.

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Justification

Saint Elizabeths Hospital

Authorization: Title 24 U.S. Code, Chapter 4, Sections 161 - 222.

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Clinical & Community Services.... | 4,132 | $77,561,000 | 4,132 | $81,744,000 | --- | +$4,183,000 |

General Statement

This appropriation supports the operation of the Saint Elizabeths Hospital, which provides treatment and rehabilitation of the mentally ill for approximately 2,700 inpatients and 3,000 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 1977 Budget requests a total authorized program of $81,744,000, an increase of $4,183,000 over a current year estimated obligation level of $77,561,000.

In FY 1976, the Department will submit legislation proposing to transfer the hospital to the District of Columbia by a date which will be mutually agreed upon. By that time the Department, in consultation with the District, will have initiated the facility construction, renovation, and management improvement activities to attempt to obtain full accreditation. Prior to the transfer, the Department and District of Columbia will develop formal agreements for the transfer, along with delegations of authority and requests for resources. The legislative proposal will also include funds for construction and renovation of SEH facilities.

Impact of 1977 budget:

The Hospital will treat an estimated 9,825 patients during 1977. A total of 4,100 is expected to be admitted, compared with 3,900 to be discharged from the rolls. In terms of daily averages, the inpatient load is expected to average 2,700, compared with an outpatient load of 3,000.

A $75,000,000 buildings and facilities appropriation to regain accreditation of the Hospital will be included in a separate legislative proposal whose goal will be the eventual transfer of the Hospital to the District of Columbia.

In its continuing effort to provide better services to its patients, the Hospital is making 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, currently serves approximately 50 patients. There have been 417 admissions into this program in sixty months. Eighteen of the program's graduates are now employed in drug rehabilitation centers throughout the country.

(c) Service to children. Services to a selected group of mentally ill youngsters cover approximately 50 patients.

(d) Intensive care units. A medical and surgical intensive care suite is being established to accommodate intensive care, post surgery and post anesthesia, and isolation units.

(e) Forensic Services. This program, under which the number of cases to determine competency to stand trial is rapidly increasing, is being improved through a more selective referral system from the District of Columbia.

(f) In 1977, 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.

(g) 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 1977 will be conducted in the areas of behavior analysis and therapy providing mental health services to the deaf, criminal behavior, psychiatric nursing, hospital and community studies, studies of families troubled by mental disorder or dysfunction, and many other areas of clinical concern.

The requested increase of $4,183,000 will cover built-in salary and wage grade pay increases, full year costs for 104 positions proposed for restoration during the current fiscal year, cost of living increases in costs of supplies such as utilities, food of patients, and fuel oil for heating. Workload data are set forth in the following tables.

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Patient Load Data

| | 1975 Actual | 1976 Estimate | 1977 Estimate |
|---|---|---|---|
| Inpatients: | | | |
| Reimbursable | | | |
| Public Health Service (Indians)... | 2 | 2 | 2 |
| D.C. (Residents)..... | 1,439 | 1,435 | 1,415 |
| D.C. (Vol. and Non-protesting).... | 608 | 604 | 601 |
| D.C. (Prisoners)..... | 267 | 266 | 264 |
| D.C. (Jury Trial)..... | 20 | 20 | 20 |
| U.S. Soldiers Home..... | 2 | 2 | 2 |
| Veterans Administration..... | 1 | 1 | 1 |
| U.S. Nationals..... | 25 | 25 | 25 |
| U.S. Prisoners..... | 5 | 5 | 5 |
| Reimbursable Totals..... | 2,369 | 2,360 | 2,335 |
| Nonreimbursable | | | |
| Military..... | 57 | 55 | 55 |
| D.C. Non-residents..... | 212 | 215 | 215 |
| Public Health Service..... | 4 | 4 | 4 |
| Virgin Islands..... | 72 | 76 | 78 |
| Other..... | 20 | 15 | 13 |
| Nonreimbursable Total..... | 365 | 365 | 365 |
| Total, Inpatients..... | 2,734 | 2,725 | 2,700 |
| Outpatients..... | 2,850 | 2,950 | 3,000 |
| Total on rolls (daily average)..... | 5,584 | 5,675 | 5,700 |
| Admissions..... | 3,911 | 4,300 | 4,100 |
| Discharges..... | 3,907 | 3,835 | 3,900 |
| Deaths..... | 225 | 225 | 225 |

SAINT ELIZABETHS HOSPITAL

Reimbursement Detail

| | 1976 Appropriation | 1977 Estimate |
|---|---|---|
| Reimbursements from Federal and Trust Funds: | | |
| Veterans Administration | $30,000 | $36,000 |
| U.S. Soldiers Home | 55,000 | 57,000 |
| Public Health Service (Indians) | 58,000 | 67,000 |
| U.S. Nationals | 649,000 | 736,000 |
| U.S. Prisoners | 109,000 | 134,000 |
| Soc. Sec. (Medicare payments) | 300,000 | 300,000 |
| General Services Administration | 18,000 | 19,000 |
| Subtotal | 1,219,000 | 1,349,000 |
| Payment received from Non-Federal Sources: | | |
| District of Columbia | 20,872,000 | 22,236,000 |
| Cafeteria sales | 87,000 | 187,000 |
| Sale of scrap | 8,000 | 8,000 |
| Subtotal | 20,967,000 | 22,431,000 |
| Total reimbursements | 22,186,000 | 23,780,000 |
| Per diem rate: | | |
| District of Columbia | $24.53 | $26.49 |
| Other | 74.99 | 78.34 |

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

Program Purpose and Accomplishments

Activity: Clinical and Community Services

| 1976 Appropriation | | 1977 Estimate | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 4,132 | $55,375,000 | Indefinite | 4,132 | $57,964,000 |

Purpose: Saint Elizabeths Hospital provides mental health treatment, care and rehabilitation services. The Hospital operates 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 clincial training for professional and related personnel. Authorization: Title 24 U.S. Code, Chapter 4, Sections 161 - 222.

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 1976: The Hospital is continuing further implementation of the unit plan with emphasis on the team approach in the treatment and care of patients. Admissions are expected to reach an all time high of 4,300; however, by providing more intensive early inpatient care and through continued emphasis on the early return of patients to productive community life, the Hospital plans to discharge approximately 3,835 patients and to achieve a slight reduction in the average daily patient load. It is estimated that 9,785 patients will be treated, including an average of 2,950 outpatients. The narcotic addiction program currently serves approximately 50 patients. Intensive care units are being established in the Medical and Surgical Branch.

Objectives for 1977: 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. A $75,000,000 buildings and facilities appropriation to regain accreditation of the Hospital will be included in a separate legislative proposal whose goal will be the eventual transfer of the Hospital to the District of Columbia.

Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Appropriation | Transition Quarter |
| Clinical and Community Services.... | $55,375,000 | $15,875,000 |

Explanation

The 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. This budget includes a supplemental request for $375,000 to support 104 positions added in FY 1976.

# HEALTH RESOURCES ADMINISTRATION

WEDNESDAY, MARCH 3, 1976.

## WITNESSES

DR. KENNETH M. ENDICOTT, ADMINISTRATOR
DR. HAROLD MARGULIES, DEPUTY ADMINISTRATOR
JAMES A. WALSH, ASSOCIATE ADMINISTRATOR FOR OPERATIONS AND MANAGEMENT
DR. DANIEL F. WHITESIDE, DIRECTOR, BUREAU OF HEALTH MANPOWER
DR. GERALD D. ROSENTHAL, DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH
MRS. DOROTHY C. RICE, DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS
EUGENE J. RUBEL, ACTING DIRECTOR, BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT
DR. CLAY E. SIMPSON, JR., ASSOCIATE ADMINISTRATOR, HEALTH RESOURCES OPPORTUNITY PROGRAMS
JEROME H. MILLER, DEPUTY DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER
JESSIE SCOTT, DIRECTOR, DIVISION OF NURSING

Mr. FLOOD. This afternoon we have the Health Resources Administration. The presentation will be made by Dr. Kenneth M. Endicott, the Administrator. We have a biographical sketch of you, Doctor, to be placed in the record at this point.

[The biographical sketch follows:]

### BIOGRAPHICAL SKETCH

Name: Kenneth Milo Endicott, M.D.

Position: Assistant Surgeon General, Public Health Service Administrator, Health Resources Administration.

Birthplace and date: Canon City, Colo., June 6, 1916.

Education: A.B., University of Colorado, Boulder, 1936; M.D., University of Colorado, Denver, 1939.

Experience: Present, Administrator, Health Resources Administration.

1969–73, Director, Bureau of Health Manpower Education.

1960–69, Director, National Cancer Institute, National Institutes of Health, U.S. Public Health Service, DHEW.

1960, Appointed Assistant Surgeon General, U.S., P.H.S.

1958–60, Associate director, National Institutes of Health.

1955–58, Chief, Cancer Chemotherapy National Service Center, National Cancer Institute.

1951–55, Scientific director, Division of Research Grants, National Institutes of Health.

1942–51, Chief, Section on Metabolic and Degenerative Diseases, Division of Pathology, National Institutes of Health.

1942, Medical Center for Federal Prisoners, Springfield, Mo.

1941–42, Maritime Quarantine Station, San Francisco, Calif.

1940, U.S., PHS Relief and Quarantine Station, Portland Oreg.

1940, Commissioned in U.S., PHS.

1939, Intern, U.S., Marine Hospital, Seattle, Wash.

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, Fla., January 9, 1970; Doctor of science (honorary), University of Colorado, 1970; Doctor of public service (honorary), Temple University, Philadelphia, Pa., May 1972.

INTRODUCTION

Mr. FLOOD. You have some people with you.

Dr. ENDICOTT. Mr. Chairman from my left, Mrs. Dorothy Rice, the new Director of the National Center for Health Statistics. Next to her, Dr. Daniel Whiteside, Director of the Bureau of Health Manpower. Next, Dr. Clay Simpson, Associate Administrator for Health Resources Opportunity Programs. Dr. Harold Margulies, Deputy Administrator. Mr. Jerry Miller, Deputy Director of our Division of Financial Management.

To his right, James Walsh, Associate Administrator for Operations and Management. Then Dr. Gerald Rosenthal, Director of the National Center for Health Services Research. To his right, Mr. Eugene J. Rubel, Acting Director of Health Planning and Resource Development. I am sure you know Mr. Charles Miller.

OPENING STATEMENT

Mr. FLOOD. All right. You have a prepared statement, Doctor? How do you want to handle this?

Dr. ENDICOTT. Mr. Chairman, I would like to put it in the record, if you don't object, and read a very short version.

Mr. FLOOD. All right, without objection, that will be done.

[The statement follows:]

Mr. Chairman and members of the committee, I am pleased to appear before the committee today to present a proposed budget for the Health Resources Administration in fiscal 1977 amounting to $506.3 million. These funds will enable this agency to continue activities critical to the improvement of our health care system—manpower and facilities development, data collection, health planning and research concerning health services delivery.

More specifically, our request includes funds to continue the health planning activities authorized by the Congress little more than a year ago. It also includes funds for a health manpower program that focuses on problems of geographic and specialty distribution of health personnel. Funds also are requested for a modest but necessary research effort into various elements of the health services delivery system, as well as to continue the agency's collection of statistical data on the Nation's health.

Our request, Mr. Chairman, assumes that certain legislative authorities will be enacted by the Congress this year, yet at the same time attempts to respond to the congressional intent inherent in existing authorities. We do not believe that the present and proposed shapes of our health resources programs are necessarily contradictory. Instead, we believe that our understanding of health resources problems is gradually improving, enabling us to adjust and improve the mechanisms which we have been employing in solving these problems.

A major factor contributing to this understanding is the statistical data gathered by this agency's national center for health statistics. Such data both describes the Nation's current health status and indicates the effectiveness of our efforts to improve the Nation's health. The Center's most recent report on the status of health in America was presented to the Congress in January. I am sure this report will provide valuable information that will be used extensively by all who are interested in improving the Nation's health care system.

For example, the report shows that the infant death rate in the United States declined from 29.3 per 1,000 live births in 1950 to an estimated 16.5 in 1974. Over the same period, life expectancy at birth increased by nearly 4 years. Another encouraging finding, the death rate for heart disease among persons aged 55 to 64 dropped almost 15 percent over the past 6 years. For the same age group, however, the report also shows a rise in the death rate from cancer of almost 4 percent.

Over the past 10 years, the report shows, many of the striking differentials in use of health services by people at different income levels have been substantially reduced, indicating improved access to health care. In 1964, 28 percent of the poor had not seen a physician within 2 years, in contrast with 17 percent in 1974. For those who were not poor in 1964, 18 percent had not seen a physician within 2 years, compared with 13 percent in 1974. Medicare and medicaid have obviously reduced financial barriers to health care for a large segment of our population.

The report also contains information on the economics of health care. For example, in families with incomes under $2,000, a group with a high proportion of elderly persons who have high health expenses, about 13 percent of the family income is spent for health care. In families with incomes of $7,500 or more, less than 4 percent of the income is used for health care.

For some years, the Center's activities have been the authoritative source of health data for government and industry. This data now becomes increasingly necessary as we examine such issues as health care financing and assuring the quality of care and as our nationwide array of new health planning agencies seeks to utilize information in developing health plans throughout the country.

Our budget request of $24 million for the Center will provide for the continued collection of important health data. Especially important, the funds sought will permit the Center to maintain the projects it has begun under the cooperative health statistics system. This is the system described to this committee last year through which nearly half the States are collecting and sharing health data with all levels of government and with private users. The cooperative system provides comparable data from much of the Nation and streamlines the collection of the data.

Another $24 million of our request is proposed to develop information of a different type by our National Center for Health Services Research. This Center also contributed to the report I have mentioned on the Nation's health status. This level of funding will support a program of intramural research conducted by Center and other PHS staff and will provide $17.8 million for extramural research grants and $200,000 for research training. The Center's efforts will address eight major health issues areas; inflation and productivity, health insurance, health manpower, quality of care, planning and regulation, health care for the disadvantaged, long-term care, and emergency medical services.

The Center has projects underway examining how alternative methods of health care delivery affect costs, the potential consequences of providing certain types of national health insurance, the utilization of nonphysician personnel to provide health care, the problems of access to medical care, and the techniques and procedures for delivering emergency medical services. Other components of the Public Health Service have been solicited by the Center to identify possible research projects of particular importance to their programs and to develop collaborative approaches which will make fullest use of research talent within the Public Health Service. Intramural projects are currently studying the effects of Canadian medicare on hospital use and costs in that country, analyzing union contracts in U.S. hospitals, developing a so-called index of adequacy of health professionals and facilities, comparing Federal employee utilization of Blue Cross-Blue Shield health insurance benefits with the Federal employee group health, or health maintenance organization, plan.

The fiscal 1976 application cycle for grants to study problems of emergency medical services is now in progress. The level of research desired by the Center will range from the development of methods to the testing of operating systems. Primary interest is in measures of effectiveness, system descriptions and relationships, policy issues, and the development and analysis of new techniques and devices in this field.

The Center's extramural program also includes the establishment of Health Services Research Centers. Ultimately we hope to establish a research center in each HEW region. Five of the new Centers established this year within academic or nonprofit research institutions, will carry out programs of research, education, and consultation focussing on local, regional, and national issues

in health services. Two others are to be special emphasis centers, concentrating their research on health care technology and health care management.

The largest portion of this agency's request—$319 million—is sought for the conduct of various health manpower programs. While the authority for nurse training programs was enacted during the past year, legislation to authorize health professions training programs is still pending before the Congress. Mr. Chairman, the request I am presenting is based on the administration's legislative proposal for health manpower—S. 2748—introduced before the Congress in December.

As you will recall from our testimony last year, authority for the health professions training programs expired in June 1974, and these programs have been conducted since that time under continuing resolutions. Although the specific health manpower programs we will be administering in fiscal 1977 have not been enacted, I believe the pending proposals are much closer to each other in content than they were a year ago. While our funding request is based on the administration's manpower proposal, the amounts also reflect our position on how these funds may best be utilized in focusing on some of our more stubborn health manpower problems.

These problems no longer consist of simple numercial insufficiency. Last year, the Nation's health professions and nursing schools produced 80 percent more graduates than in 1964. Over the past 10 years we've helped build 21 medical schools, 8 dental schools, 1 school of osteopathy and 1 school of veterinary medicine. Since 1965, 215 nursing schools have received Federal grants to help build new facilities or renovate existing ones. In the allied health field, our junior and senior colleges have more than doubled their number of training programs over the past 10 years, and the number of graduates in these programs last year was more than 54,000—almost 6 times the number of a decade ago.

Projections of health manpower supply indicate that maintenance of the present and planned output capacity of our health professions schools will by 1985 increase the number of physicians by more than 50 percent and the number of dentists by 40 percent over the 1970 figures. If we maintain our current and planned output capacity in nursing, we anticipate nearly a 60-percent increase in registered nurses from 1970 to 1985.

What has not responded as well to our previous manpower programs efforts has been the geographic and specialty maldisrtibution problems of our health personnel. There are States with one practicing physician for each 400 persons, while other States have over 1,000 persons per physician. There are about 500 persons for each physician in our largest metropolitan areas, and over 2,000 per physician in small, nonmetropolitan counties. The distribution is even more disparate for medical specialists, and there are similar urban area concentrations for dentists, nurses, and other health professionals.

Thus we are proposing continuation of basic institutional support through capitation grants, but requiring participating schools of medicine, osteopathy and dentistry to set aside a specified percentage of first-year places for applicants who agree to participate in the new health service scholarship program. These schools would also have to establish and maintain an identifiable unit for training in primary care and maintain a specified percentage of their residency positions in family medicine, general internal medicine, general, pediatrics, or general medicine.

Capitation support for schools of veterinary medicine, optometry, and podiatry, would be maintained in fiscal 1977, but our legislative proposal would phase out such support to these schools beginning in fiscal 1978.

At the same time, we are requesting funds to permit combining and expanding our existing scholarship programs into a single program providing scholarships to medical, osteopathic, and dental students in exchange for service in a manpower shortage area, the Public Health Service, or other Federal health services. With such scholarships running 2 to 4 years, at $3,600 per year, the request would support approximately 4,650 students during fiscal 1977.

A substantial program of special projects is proposed which will have immediate and direct effect. Among the proposed activities are continued support for 143 family medicine residency programs and support for 64 residency and 10 training programs in medical and dental primary care. Other special project programs will consolidate support for improved training in veterinary medicine, optometry, pharmacy, and podiatry; improve and expand public health training in such areas as health services administration and health planning; coordinate allied health training programs and explore specific allied health

occupations and how they can contribute to improved productivity and distribution of our health services. The proposed special project funding also provides training for an estimated 2,700 physician assistants, 845 expanded function dental auxiliaries, and 2,000 TEAM dentistry practitioners.

Since 1972, 11 area health education centers (AHEC's) have been conducting innovative programs training health personnel in underserved areas, simultaneously encouraging students to consider future practice in these areas while improving health services in those areas. Special project funding would permit increasing the number of AHEC projects to 19 and could raise the number of students participating to as much as 38,000.

Disadvantaged students, who currently are assisted into health career pathways through the special health career opportunity grant program, would continue to be served under the funding requested for special projects. About 3,500 students are expected to benefit from this support through recruitment and retention programs conducted by 50 projects throughout the country.

The nurse training funds requested are intended to provide continued improvement in nursing education, with emphasis on increasing the number and distribution of nurses prepared for expanded roles in primary care, prevention, and clinical specialties, as well as for teaching, administration, and supervision. We are seeking increased funding for nurse practitioner training and advanced nurse training.

The substantial increases in nursing school enrollment over the past decade has lessened the need for substantial programs of student assistance in this field, with certain exceptions. Consequently, funds are requested to maintain loans and scholarships only for those nursing students who have previously received such assistance. Students needing financial assistance have access to the expanded basic opportunity grants program in the Office of Education, while students seeking certain advanced training previously financed through nursing traineeships will have access to the Office of Education's guaranteed loan program.

We have maintained consistently that nurse training programs have not demonstrated any significant dependence on the capitation grant program as a source of institutional support. Consequently we again are proposing to eliminate this program for the coming year, and are requesting modest funding for a financial distress program that can be used for those nurse training programs faced with emergency financial situations or in danger of losing accreditation.

The next major portion of this agency's request consists of $90 million for health planning and resources development activities. This sum is for the continued implementation of the health planning program established under the Health Planning and Resources Development Act of 1974. Given the complexity, diversity, and interrelationships that characterize the Nation's health system, it is clear that well-informed, rational planning is a prerequisite to any substantial improvements in the delivery of health services. The health planning mechanism authorized by the recent legislation is intended to fulfill that requirement.

Our request would provide $61.5 million for the operation of the nationwide network of Health Systems Agencies (HSA's). About 210 of these agencies will be conditionally designated in fiscal 1976 and will begin a range of health planning activities which ultimately will increase the accessibility, acceptability, continuity, and quality of health services in their respective areas, while restraining increases in health costs and preventing unnecessary duplication of services and facilities. In 1977, about 110 of these HSA's will receive full designation, with the remainder retaining their conditional status. Our request would provide an average of $385,000 per fully designated agency.

Another $19 million is requested for State Health Planning and Development Agencies. We expect these agencies to be conditionally designated in 1976 and to retain their conditional status in 1977. Their functions include establishing procedures and criteria for review of health systems changes, integrating HSA health plans into a State health plan, administering the facilities construction program, implementing certificate-of-need laws, and providing staff support to the Statewide Health Coordinating Council. Our request would provide an average of $337,500 per State agency, which when added to State matching funds, would provide a total State agency budget averaging $450,000.

Our funding level also provides vitally needed technical assistance activities for State and local agencies, including the operation of the National Health Planning Information Center for information exchange and the conduct of training and consultation activities for health planners by 10 centers for health planning, now being established in each of the HEW Regions. These centers are ex-

pected to train some 10,000 staff and board members in health planning functions during 1977.

Six demonstration projects to test the effectiveness of regulating rates for health care services would be awarded from requested funds to States wishing to control rate setting. These projects would be coordinated with the Social Security Administration and would be conducted in conjunction with section 222 of the Social Security Amendments of 1972. Participation in the program by the States is optional.

As you know, Mr. Chairman, the health planning program has been proposed for inclusion in the administration's block grant proposal, which would transfer responsibility for the program to the States. Until such time as the proposal may be enacted, we are requesting funding under existing authorities so that the momentum generated in establishing the new health planning program will not be lost and to assure program continuity.

Also in connection with the health planning program I would like to explain our position regarding medical facilities construction financing. The Health Planning and Resources Development Act requires that health systems agencies and State agencies be established prior to the approval of State medical facility plans for construction. Because of the complexities and length of time involved in establishing the health planning agencies and in spite of our original projecting it is not realistic to expect that any title XVI construction activities can be financed in 1976. For these same reasons we are not anticipating sufficient approved plans to implement this program in 1977, and are therefore not proposing any funding for title XVI in 1977. We are, however, requesting $31 million for interest subsidy payments for loans previously committed under the medical facilities construction program.

We are also requesting $4 million for the payment of sales insufficiencies and interest losses as may be required due to outstanding beneficial interest or participations in the Health Profession Education Fund and Nurse Training Fund.

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

Dr. ENDICOTT. Mr. Chairman and members of the committee, I am pleased to appear before the committee today to present a proposed budget for the Health Resources Administration in fiscal 1977, amounting to $506.3 million. Our request assumes that certain legislative authorities will be enacted by the Congress this year, yet at the same time attempts to meet the congressional intent inherent in existing authorities.

We do not believe that the present and proposed shapes of our health resources programs are necessarily contradictory. Instead, we believe that our understanding of health resources problems is gradually improving, enabling us to adjust and improve the mechanisms which we have been employing in solving these problems.

A major requirement for that understanding is the statistical data gathered by the National Center for Health Statistics, both in describing the Nation's current health status, and for indicating the effectiveness of our efforts to improve the Nation's health. The Center's most recent report on the status of health in America was presented to the Congress in January. I am sure it will be utilized extensively by all of us who are concerned with the Nation's health problems.

Our budget request of $24 million for that Center will permit the continued collection of such important health data. Especially important, the funds sought will permit the Center to maintain selected projects it has begun under the cooperative health statistics program.

Another $24 million is requested to develop information of a different sort by our National Center for Health Services Research. That Center's efforts will address eight major health issue areas—inflation and productivity, health insurance, health manpower, quality of care,

planning and regulation, health care for the disadvantaged, long-term care, and emergency medical services.

The largest portion of this agency's request, $319 million, is for the conduct of various health manpower programs. While authority for nurse training programs was enacted during the past year, legislation to authorize health professions training programs is still pending before the Congress, and our request is based on this administration's health proposal, S. 2748. Authority for the health professions training programs expired in June 1974, and these programs have been conducted since that time under continuing resolutions—I might add, with some difficulty.

Projections of health manpower supply indicate that maintenance of the present and planned output capacity of our health professional schools will, by 1985, increase the number of physicians by more than 50 percent, the number of dentists by 40 percent, and the number of nurses by 60 percent as compared with 1970. What has not responded as well to our previous manpower programs has been the geographic and specialty maldistribution programs of health personnel. Thus our proposal continues basic institutional support, but requires participating schools of medicine, osteopathy and dentistry to set aside a percentage of first year entering places for applicants who agree to participate in the national health service scholarship program. These schools would also have to establish and maintain an identifiable unit for training in primary care, and maintain a percentage of their residency positions in family medicine, general internal medicine, general pediatrics, or general medicine.

At the same time, we are requesting funds to combine and expand our existing scholarship programs into a single program providing scholarships to medical, osteopathic, and dental students, in exchange for service in manpower shortage areas, the Public Health Service, or other Federal health service.

A substantial program of special projects is proposed which would support family medicine residencies, residency and training programs in medical and dental primary care, would consolidate support for improved training in veterinary medicine, osteopathy, pharmacy, and podiatry, improve and expand public health training in such areas as health services administration and health planning, and coordinate allied health training and relate it to improved productivity and distribution of health services.

Special project funding also provides training for physician assistants, expanded function dental auxiliaries, team dentistry practitioners, and would increase to 19 the number of area health education centers which have been training health personnel in underserved areas. Disadvantaged students who currently are assisted into health career pathways through special health career opportunity grants would continue to be served under the funding requested here for special projects.

The nurse training funds requested are to continue improvements in nursing education with emphasis on increasing the number and distribution of nurses prepared for expanded roles in primary care, prevention, and clinical specialities, and in teaching, administration, and supervision.

The Agency request also includes $90 million for continued implementation of the Health Planning and Resources Development Act of 1974. Our request would provide $61,500,000 for the operation of the nationwide network of health systems agencies.

In 1977, about 110 of these HSA's will receive full designation, with the remaining 100 retaining their conditional status. Another $19 million is requested for State health planning and development agencies to establish procedures and criteria for review of health systems changes, integrate HSA plans into a State health plan, administer the facilities construction program, implement certificate of need laws, and provide staff support to the statewide health coordinating council mandated by the legislation. Our funding level also provides technical assistance activities for State and local agencies. Six demonstration projects to test the effectiveness of regulating rates for health care services also would be awarded from requested funds to States wishing to attempt to regulate rate setting.

As you know, Mr. Chairman, the health planning program has been proposed for inclusion in the administration's block grant proposal which would transfer responsibility for the program to the States. Until such time as the proposal may be enacted, we are requesting funding under existing authorities, so that the momentum generated in establishing the new health planning program will not be lost and will assure program continuity.

Also in connection with the health planning program, I would like to explain our position regarding medical facilities construction financing. The Health Planning and Resources Development Act requires that health systems agencies and State agencies be established prior to the approval of State medical facility plans for construction. Because of the complexities and length of time involved in establishing the health planning agencies, and in spite of our original projections, it is not realistic to expect that any title XVI construction activities can be financed in 1976.

For these same reasons, we are not anticipating sufficient approved plans to implement this program in 1977 and are therefore not proposing any funding for title XVI in 1977. We are, however, requesting $31 million for interest subsidy payments for loans previously committed under the medical facilities construction program.

We are also requesting $4 million for the payment of sales insufficiencies and interest losses as may be required due to outstanding beneficial interest or participation in the health professions education fund and nurse training fund.

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

### REDUCTION IN FUNDING FOR HEALTH STATISTICS

Mr. Flood. Well, now, Doctor, we are aware that your national center for health statistics played a very important role in the preparation of that document, "Health—U.S. 1975." That was a very excellent document.

In view of the excellent work that was done in that document, will you explain why you are cutting the budget in this great center by $1,636,000? Is that the way you reward good work—cut them? They do a great job, so you cut them, is that it?

Dr. ENDICOTT. Mr. Chairman, I think that this is clearly a spartan budget, and reflects the administration's attempt to live within tight budget restraints. I requested more funding than this, and so did the Department, sir.

Mr. FLOOD. No sense in beating you over the head. Enough is enough. Can you tell us this: What is the impact of the cut? Specifically, I mean which programs in the area are going to be the most affected?

Dr. ENDICOTT. There will be some effect across the board. But the program most seriously affected by holding back funding for health statistics is the cooperative health statistics system. At the present time we are in the process of developing, through a series of contracts with the States, the capability to generate the data needed at the local, State, and National levels.

In some States and for certain components these contracts are operational and simply represent the purchase of data through apparatus that we have already tested. Additionally we have some R. & D. contracts to develop data systems that we need but which requires development. Both of these efforts will have to be put on a slow track if funding is tight.

I think our new Director of the National Center for Health Statistics might wish to comment on this and amplify it. But that essentially is the situation. A slowdown is what it amounts to.

Mrs. RICE. Mr. Chairman, we now have 39 States participating in one or more of these data components of the cooperative health statistics system that Dr. Endicott mentioned. Twenty-nine of these States are in what we call the implementation stage. That is, they are producing data at an acceptable level. in at least one component, and are transmitting the data tapes to the National Center for Health Statistics. The budget does provide for contining the implementation contracts that are now in force in these States, but we may have to terminate contracts with some States which are in the research or development stages.

Mr. FLOOD. I understand that. I was asking what programs, of all those affected. would be the most affected.

Mrs. RICE. The cooperative health statistics system would be affected most.

COOPERATIVE HEALTH STATISTICS SYSTEM

Mr. FLOOD. That is one of the systems we talked about in the past—this national cooperative health statistics system. I was going to ask you, what progress are you making in the implementation of the system?

Mrs. RICE. That is the question to which I was responding. We have made progress. We are concerned that in those States in which we have research and developmental contracts, we will not be able to continue the work that was started, and therefore will not be in a position to get the data flowing from the States to the various multiple-data users.

Mr. FLOOD. Well, can you explain to the committee why is it necessary to establish a national cooperative health statistics system? Why is that necessary?

Dr. ENDICOTT. I will try to answer that, and Mrs. Rice may want to supplement it. The existing national health statistics have been collected largely on the basis of a carefully structured national sample.

This gives us national aggregate figures, but the data cannot be arrayed to give data at the State or sub-State level, or compilations of that sort.

If we are to rearrange things so that the data systems are really useful to the States and to the sub-State areas, then we have to go about it a different way. We really have to collect the data from the bottom up, instead of by national sample. That is what this cooperative health statistics system is about.

Mr. FLOOD. Well, this is the Appropriation Committee. Are the States making any financial contribution to the establishment and the operation of these cooperative systems?

Dr. ENDICOTT. Yes, indeed.

Mr. FLOOD. All right.

That's what we are here for. The answer is, surprisingly, yes.

Dr. ENDICOTT. I don't know what percentage they are paying, but, for example, States operate out of their own pocket such vital statistics efforts as registration of births, deaths, marriages, and divorces. They also operate licensing boards for health manpower and certification of health facilities which provide the base for our data collection efforts in these areas. Additionally the States are contributing to new data collection activities such as those in the area of hospital care data.

### PLANS FOR THE COOPERATIVE HEALTH STATISTICS SYSTEM

Mr. FLOOD. Considering the level of funding you requested for this National Center, what plans do you have now for expanding the cooperative system in 1977?

Dr. ENDICOTT. The Center has plans for an accelerated rate of implementation over and above what this budget would provide, and the States are in a position to respond. It is a question here of how much of the budget the Federal Government is prepared to devote to this area. The budget I am defending here——

Mr. FLOOD. How much is this Federal budget asking for—that is the first thing.

Dr. ENDICOTT. Yes, sir. That is $24 million.

Mr. FLOOD. All right.

Dr. ENDICOTT. We could spend more, obviously.

Mr. FLOOD. You said that—I didn't. In spite of all these very nice things I have said about the National Center for Health Statistics, let's not kid the troops. This is still a very difficult program for most Members of Congress to relate to.

Dr. ENDICOTT. Yes, sir.

### THE NEED FOR NATIONAL HEALTH STATISTICS

Mr. FLOOD. That is to say, we don't know anybody that died from this. We don't have a lot of people writing letters and petitions and all that urging us to increase this Center's budget—nothing like that. Now, what arguments can we have on the floor of the House to support the program and its possible expansion?

Dr. ENDICOTT. Well, let me make a try, and then turn to Mrs. Rice.

I have been around the health area all my adult life. And I believe that sound data about what is happening in the health field is one of the most important things of any program, whether it is a research

program of the National Cancer Institute, or whether it is the Health Resources Administration and HEW.

We have had a tight budget ever since I took over the Health Resources Administration. We have had very tight budgets for the National Center, which I have been supplementing as the law permitted, with funds from other programs having legitimate data requirements. My money is where my mouth is. I think this is an absolutely vital program.

Mr. PATTEN. You don't have to press that. Everybody wants these figures.

Dr. ENDICOTT. Yes, they do.

Mr. FLOOD. What I mean is, are you doing some things now that can be of immediate benefit to the subcommittee when we have to meet this problem, of deciding in all this resource allocation, when we cut up the pie? Where are there any immediate benefits here to help us?

Dr. MARGULIES. Mr. Chairman, I appreciate that you have been for some days—and in your case for some years—holding hearings on appropriations, trying to decide how the Federal money can best be used in the interest of the health affairs of this country. Without these data you have no basis upon which to decide where the problems are, what progress we are making, what is happening with infant mortality rates, what the differences are from urban to rural areas, from rich to poor, and from black to white. The only valid basis upon which you can determine where the money should go, whether it is mental health or research, is on this kind of information. You need it to develop the questions you ask and for the decisions you make, whether it is apparent or it is hidden. It is the direct kind of guidance you need in the kinds of actions you are taking.

Mr. FLOOD. Dean Pound, of the Harvard Law School, asked me a question. I went on for about a half hour and he let me go on. And I finally shut up. And then he said, "Mr. Flood, you have just restated the question—what is the answer?"

You just restated what I said. But what are you giving us when we have to make the decision? You have restated our problem.

Mrs. RICE. Mr. Chairman, if I may: We are currently spending in the United States more than $125 billion for health and medical care. And I think that it behooves us to provide the data by which we can assess the progress we make in the expenditure of these funds. And the kind of information that we have been providing is illustrated by this report that we presented to the Congress on health in the United States for 1975. Without additional support, we could not continue the Cooperative Health Statistics System, and we would have to slow down some of our other activities, and reorder our priorities in health statistics.

We can provide for the record specific examples of the kinds of information we are currently getting which might be helpful to you.

Mr. FLOOD. All right, let's have about a half dozen of those. That is what I am talking about.

[The information follows:]

Examples of some of the data produced by the National Center for Health Statistics:

. Data on illness, injuries, disability, and costs and uses of medical services is obtained from personal interviews with residents of 40,000 households each year. This data provides us with a good base to look at the overall health status of our population and shows us what the relationships are of health and medical care to a wide variety of social, economic and demographic variables. One of several uses of this data is to derive prevalence rates for various diseases and to determine the impact these diseases have on people's lives. The Assistant Secretary for Health and others use this to make policy decisions regarding what priorities should be established in the health care and health research fields.

. Data on nutritional status, health-related body measurements, prevalence of chronic diseases and related health care needs, and physical and intellectual growth and development patterns are obtained by conducting physical examinations on a selected sample of the U.S. population. Recent data from this survey includes information on dietary intake, clinical findings, prevalence of emphysema, dermatologists' findings on skin disease, measures of auditory acuity, and assessments of pulmonary function. The data is useful in comparing perceived health conditions with actual conditions as found in the survey. The data are in demand by health planners, educators, epidemiologists, clothing manufacturers, research workers, and professionals in a wide range of specialities such as ophthalmology, dermatology, audiology, and cardiology. A report currently being prepared which should prove interesting compares the nutritional status of like populations participating and not participating in food programs.

. An inventory of family planning clinics and the nation's inpatient facilities including hospitals and nursing homes, is maintained and updated annually. This file also contains data on the staff of these institutions and on the services provided. The file serves as a universe from which samples may be selected for particular in-depth studies and it also serves as a current source of baseline statistical data. Currently this file is the only source of comprehensive data on health facilities that is available and suitable for local health planning.

Under the facilities component of the Cooperative Health Statistics System, this file is being extended to the State level and is being combined with the licensing and inspection functions of the State to produce more timely and accurate data in a uniform manner. At the State level the inventories may include all types of facilities--short-term and long-term inpatient facilities, outpatient clinics, home health services, ambulance services and others. These data are used by State and local government for certificate of need programs, rate setting, projecting costs for programs such as Medicaid, publishing directories for use in referring patients, and many other uses.

. Data on services provided to ambulatory patients including information on their demographic characteristics, what prompted them to see a doctor, the physician's diagnostic procedures, referral procedures, and patient management are collected from sample of patients seen in 3,000 physicians offices throughout the country. The first cycle of this survey has recently been completed and this will provide us for the first time with national data on why people go to the doctor and what happens to this once they are in the physician's offices.

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. Data on hospitalization episodes in short-stay hospitals that describe the characteristics of patients, their diagnoses, the procedures performed, and their length of stay are collected by the National Hospital Discharge Survey. This Survey, which provides national level data, is presently a small sample survey of hospitals but, when the hospital care component of the Cooperative Health Statistics System is fully implemented in all States, the data will be obtained from statewide hospital discharge abstract systems and will be of sufficient detail to meet the needs of health programs, such as Professional Standards Review Organizations, which are operating at the local level.

. The Vital Statistics system is the oldest and most successful program operating in the Federal-State cooperative mode. Data are collected and published on births, deaths, marriages, and divorces. The data are used to prepare intercensal population estimates for States, counties, metropolitan areas, and even smaller geographic units. These estimates are used for a variety of local and national purposes such as the distribution of Federal funds among the States according to various formulas. Other uses are the preparation of life tables for insurance underwriters, estimating the prevalence of various morbid conditions, epidemiological surveillance, purging various files of persons known to be dead, projecting future school enrollments, and literally hundreds of other uses. Most of the uses are very similar at the State and national levels.

Some specific examples of use of data from the Cooperative Health Statistics System at the State and local levels follow:

Washington - they have discovered that with a slight modification of the minimum basic data set being collected on health facilities that they will have the basic information required for rate setting.

Pima County, Arizona - they have developed a computerized mapping technique that permits the identification of individual hospital service areas and the health needs of these areas by using data from many different sources.

Wisconsin - a baseline study has been done on the utilization of hospital emergency rooms according to the characteristics of the patients, their medical problems, and the services provided. This data is being utilized to develop standards for staffing and equipping hospital emergency rooms.

Massachusetts - a survey has been completed on the length of time patients spend in short-stay hospitals waiting for placement in nursing homes. This study identifies the patient characteristics, their conditions, and types of care required. The data is being used for the certificate of need program for new or expanded nursing home facilities.

Wisconsin - combining data from their annual survey of nursing homes and Medicaid data on individual nursing home rates they were able to provide the State legislature with precise estimates regarding the costs of various alternative proposals being considered. This came at a critical time when the State's nursing homes were praying for relief from a freeze on Medicaid reimbursement rates.

Vermont - utilizing data from their hospital discharge survey they were able to identify those parts of the State where nearly every child had a tonsillectony as compared to other areas where very few did. In cooperation with the hospitals and the State medical society it was determined that this phenomenon was attributable primarily to two physicians.

Rhode Island - recently published a patient origin study for the major hospital services (medicine, surgery, obstetrics, pediatrics) in each of fifteen short-term general hospitals according to each census tract in Rhode Island. Such detailed analysis permits each hospital to more accurately project staffing needs, beds, and speical equipment as well as providing planning agencies with more reliable descriptions of local health problems.

IMPLEMENTATION OF THE HEALTH PLANNING PROGRAM

Mr. FLOOD. Now, Doctor, you are asking for $80 million for health planning and resources development.

Dr. ENDICOTT. Yes, sir.

Mr FLOOD. How many of those 211 health system agencies do you expect to have in operation in 1977?

Dr. ENDICOTT. We estimate that all 211 will be in operation in 1977.

Mr. FLOOD. In that justification material you sent us here, you refer to conditional and fully designated.

Dr. ENDICOTT. Right.

Mr FLOOD. What is the difference between those two?

Dr. ENDICOTT. "Conditional" is the first designation. They all go through a conditional stage. As soon as they are judged to be ready to be fully operational, then they are fully designated. It is our estimate that about 100 will be fully operational by the end of 1977, and the others will become fully operational in the following year.

Mr. FLOOD. What level of support will each of those health system agencies have in 1976 and in 1977? What I mean by that is what is the average support for the conditional and for the fully designated?

Dr. ENDICOTT. I would like to call on Mr. Rubel for that.

Mr. FLOOD. Just a ballpark figure.

Mr. RUBEL. If I recall correctly, we are talking about something in the order——

Mr. FLOOD. For the conditional.

Mr. RUBEL. For the conditional, $187,000, and for the fully designated, $385,000.

Mr. FLOOD. What is the maximum level of support that you are allowed to give a health system agency under the law?

Dr. ENDICOTT. It is determined by a formula prescribed in the law.

Mr. FLOOD. There is a maximum.

Dr. ENDICOTT. Yes, sir. And it is based on the population served, plus some adjustment for the amount of matching money that we are able to get.

Mr. FLOOD. You cannot answer that question directly, can you?

Mr. RUBEL. Mr. Chairman, there is an authorization level. That is $125 million. The statute provides a formula of 50 cents per capita, plus 25 cents per capita additional if it is matched. That would give us something in the order of $160 million, which is obviously above the authorization level. I think the authorization level was constructed assuming that not everyone would be at a level that could utilize the 50 cents.

Mr. FLOOD. All right.

Dr. ENDICOTT. The maximum population served under the law for a given area is 3 million. At 50 cents per capita, forgetting about matching, an agency of that size would receive $1,500,000. And the smallest population is supposed to be a one-half million, although some are smaller than that.

TIMING OF AWARDS

Mr. FLOOD. By what date do you expect to award a grant to all of those 211 designated areas?

Dr. ENDICOTT. By the end of June.

Mr. FLOOD. How many have you awarded up until this date?

Dr. ENDICOTT. No awards have been made to date. The review cycle for the first wave is partially complete. The applications are in hand, and the awards will be made in March.

Mr. FLOOD. Have you received a grant application from all of the 211 designated areas?

Dr. ENDICOTT. No, sir. The rest of them will come in a little later and will be acted on by the end of June.

Mr. FLOOD. You have included in your budget $19 million for grants to State health planning and development agencies. How many of these have you awarded to date?

Dr. ENDICOTT. None. We expect to award those by the end of June.

Mr. FLOOD. Again, what level of support must the States provide under that State planning grant?

Mr. RUBEL. At least 25 percent of the total funding of the agency must come from the State.

Mr. FLOOD. By the way, have you published all of your regulations in final form for the health planning program?

Dr. ENDICOTT. No, sir.

Mr. FLOOD. When do you expect to have them all published?

Dr. ENDICOTT. The law itself prescribes a pretty tight deadline. We have slipped a little bit.

Mr. FLOOD. When do you expect to have them published—all the regulations?

Dr. ENDICOTT. All of them, probably by the end of fiscal 1977.

Mr. FLOOD. That being so, will that lack of the regulations slow down the development of the program at all?

Dr. ENDICOTT. If we are able to stick to our planned target dates, no, sir.

### PLANNING METHODS AND TECHNICAL ASSISTANCE

Mr. FLOOD. Now, you want $7.5 million for planning methods and technical assistance. And to date you have appropriated $15 million—we have already given you that much for that purpose.

Dr. ENDICOTT. Yes, sir.

Mr. FLOOD. What have you accomplished with that money that you want $7.5 million more? We have given you $15 million. Now you want $7.5 million more. Why do you need another $7.5 million? What have you done with the $15 million that you need another $7.5 million?

Dr. ENDICOTT. We have funded a number of contracts. We have designated five centers to provide technical assistance, and expect to designate an additional five, so that there will be one for each of the HEW regions.

Mr. FLOOD. For the record, identify them geographically.

Dr. ENDICOTT. Yes, sir.

[The information follows:]

### GEOGRAPHIC LOCATION OF HEALTH PLANNING CENTERS

The following five Centers have already been established:

| Region: | *Location of center* |
|---|---|
| I | Boston, Mass. |
| II | Syracuse, N.Y. |
| III | Fort Washington, Pa. |
| IV | Atlanta, Ga. |
| VI | Houston, Tex. |

The Department intends to establish additional Centers for Health Planning in Regions V, VII, VIII, IX, and X by June 30, 1976.

Mr. FLOOD. Now, we took a look at your budget request for the National Center for Health Services Research and Development.

Mr. ENDICOTT. Yes, sir.

Mr. FLOOD. And there we find a request for $1.3 million for "planning and regulation." When we read the budget justification you have here, it appears that this outfit wants to do the same thing that you are proposing to do with the $7.5 million you were just talking about. The only difference seems to be what they call in TV shows buzz words. Why should we approve either one of these requests, that being so?

Dr. ENDICOTT. The funds requested under the planning legislation are essentially for technical assistance, to help people with the state of the art, what is known now. The funds for the National Center for Health Services Research are research money to develop new and better methods for planning and resource development. One fund is technical assistance and the other fund is research.

Mr. FLOOD. How much of that $7.5 million is for the development of the planning methods and how much for the technical assistance?

Mr. RUBEL. I would say none of the $7.5 million is for the development of methodologies. A lot of the money is being used to bring together, to assess, to evaluate methodologies that already exist.

Mr. FLOOD. You are talking about two things—planning methods and technical assistance.

Dr. ENDICOTT. We are talking about research and technical assistance.

Mr. FLOOD. How much of the $7.5 million is for each one of those two?

Mr. RUBEL. I would say approximately $4 million of the $7.5 million is for the centers for health planning, which will be providing technical assistance. The other $3.5 million is primarily for pulling together what we know and attempting to package it in such a way that it can be used.

Mr. FLOOD. What do you mean by technical assistance in this case?

Mr. RUBEL. Essentially training programs of all sorts. We have approximately 10,000 people across the country who are either going to be staff of planning agencies or to serve on the board of directors of these agencies. And they need to have a much better understanding of what it is they are going to be doing.

Mr. FLOOD. I'll tell you what you do. Put in the record a list of the amount that you spent for development of these planning methods, fiscal 1975 and fiscal 1976, and, of course, how much you intend to spend in 1977.

Mr. ENDICOTT. Yes, sir.

Mr. FLOOD. And do the same thing for the technical assistance support.

[The information follows:]

FUNDING LEVELS FOR PLANNING METHODS/TECHNICAL ASSISTANCE

| Fiscal year | Total | Methods development | Technical assistance |
|---|---|---|---|
| 1975 | $10,000,000 | $3,500,000 | $6,500,000 |
| 1976 | 7,500,000 | 3,500,000 | 4,000,000 |
| 1977 | 7,500,000 | 4,000,000 | 3,500,000 |

The amounts for technical assistance include funding for the National Health Planning Information Center, the Centers for Health Planning, and related regional technical assistance activities.

INTRAMURAL RESEARCH

Mr. FLOOD. Now, the National Center for Health Services Research and Development. Here you want $24 million. And of that $6 million is for intramural research.

Dr. ENDICOTT. Yes, sir.

Mr. FLOOD. What kind of intramural research—and I emphasize the "intra" for obvious reasons—projects are you supporting, and which of the agencies are you working with on that?

Dr. ROSENTHAL. Well, the largest project currently underway is with the Public Health Service hospitals. They are moving to a professional standards review system in the hospitals. We have taken the opportunity to work with them, to stage this review activity, so that we can see whether in fact it makes any real difference. We also have a project under development with the Indian Health Service—of modest scale—to test some of the health status measures which are called for in things like the planning legislation and other activities.

We are also developing, with the National Center for Health Statistics, a rather extensive analysis of medical care expenditures, and using that to generate some estimates of the impact of national health insurance proposals.

Mr. FLOOD. Now, your budget here shows you have 38 people working on those intramural research activities in 1976. Now that is what—about 15 percent of your total manpower. That percentage seems pretty small in view of what a big deal you are talking about here. Just how committed are you to carrying out this mandate that you say you have to develop a strong intramural research program? Are you committed to this? Are you very committed to it?

Dr. ROSENTHAL. Totally committed.

Mr. FLOOD. Totally?

Dr. ROSENTHAL. Absolutely.

Mr. FLOOD. If that is so, will you explain to us why the number of people for something that is so good, and you are so totally committed to is not greater?

Dr. ROSENTHAL. There are two answers to that.

Mr. FLOOD. One will do.

Dr. ROSENTHAL. One answer is that there are people in other agencies who are contributing to the research effort, who are not carried on our personnel rolls.

Mr. FLOOD. I know that.

Dr. ROSENTHAL. The other answer is that we have essentially shrunk in size over the 2 years since that legislation was passed, and we have attempted within the constraints of our own personnel ceilings to allocate as many resources to this effort as we could without subverting the rest of the program.

Mr. PATTEN. The Star has a column called Gobbledygook. You could send that in.

Mr. FLOOD. That goes on here by the hour.

### RESULTS OF HEALTH SERVICES RESEARCH THAT HAVE BEEN INCORPORATED INTO THE HEALTH CARE DELIVERY SYSTEM

Mr. FLOOD. Well, I tell you what you do, suppose you identify three or four projects that you have supported now that subsequently were picked up by this health care delivery system, three or four of them?

Dr. ENDICOTT. Yes, sir, we will be delighted.

Mr. FLOOD. These are projects where there is new access to health care, where you reduced or contained the medical costs, things of that nature.

Dr. ENDICOTT. Yes, sir.

[The information follows:]

HEALTH SERVICES RESEARCH

Research Used by Health Care Delivery System

I. Project Title: "Inventory and Assessment of Health Agency Planning and Evaluation Studies"

Principal Investigator/
Institution: Elliott Hurwitz, Ph.D.
The Orkand Corporation
8630 Fenton Street
Silver Spring, Maryland 20910

Research Objectives and Design: The purpose of this contract was to describe and evaluate planning and evaluation technique used by Comprehensive Health Planning Agencies, Regional Medical Programs, and Experimental Health Services Delivery Systems for possible use by proposed health authorities. The contractor identified, described and assessed those planning and evaluation techniques, processes, and data systems devised and/or employed by CHP's, RMP's, and EHSDS that have been relatively useful in achieving agreement and making planning decisions, and which appear to be relevant to health planning efforts now and in the immediate future. Twenty-seven agencies were contacted and asked to submit planning and evaluation studies in seven specific subject areas (Health Care Finance and Community Funds Flow; Ambulatory Care; Long Term Care; Hospital Care and Utilization; Emergency Medical Services; Consumer Health Status and Need; and Medical Specialty Needs). These planning studies were subjected to an internal review by the contractor, a review by subject-matter consultants for relevance, and then a review of methodological soundness. A methodology for reviewing and scoring the projects was developed and used, and an evaluation of the community funds flow accounting technique was also carried out.

Summary of Findings: The result is a six-volume Planning and Evaluation Manual to be used in six specific health planning subject areas. An index to the six-volume set was prepared which lists the studies by methodological technique employed (analysis of secondary source data; facility or service inventory; literature review; mathematical modeling; physical or functional patient assessment; record review; site visit and survey), by subject area and by target group (consumer; provider).

Evaluation of the community funds flow technique showed that the local EHSDS agencies were able to utilize funds flow with varying degrees of success, but that more than half of the agencies have used the technique. Their experiences indicate that there is no one best way of data collection. Many of the agencies did cite the need to account for import or export of services, because of the profound effect this factor had on results.

II. Project Title: "Computer Stored Ambulatory Record" (COSTAR)

Principal Investigator/
Institution: G. Octo Barnett, M.D.
Laboratory of Computer Sciences
Massachusetts General Hospital
Harvard Community Health Plan
Harvard Medical School
Boston, Massachusetts

Research Objectives and Design: The objective of this project was the development of a relatively inexpensive modular system for facilitating data handling within health care facilities such as hospitals, ambulatory clinics and HMO's. The research was intended to test the proposition that computerizing the medical record and using computer programs for outpatient scheduling and history-taking enhances patient management and institutional administration, and can help to control rising costs.

Summary of Findings: Using the MUMPS language which they had previously developed and a bank of mini-computers at Massachusetts General Hospital, the investigators set up a computerized, streamlined medical record system at the Harvard Community Health Plan (HCHP). Data input and output from administrators, physicians or laboratory is channeled through these computers by means of interactive terminals. All administrative and medical data flow through the system in a highly organized way, eliminating the old paper record which by its sheer bulk and inherent lack of organization hindered the practice of good medicine.

The HCHP is satisfied that the computerized system meets the varied requirements of its 50,000 HMO subscribers in an efficient, cost-effective way. Because all information related to patient history and treatment is stored within the computer, the system has also made possible the establishment of a workable quality assurance program. Although the NCHSR grant originally paid the entire cost of operating the system, patient fees to defray half the cost are now being collected. Furthermore, HCHP has recently established a new HMO in Cambridge that uses the COSTAR system on a self-supporting basis.

III. Project Title: "A Program of Ambulatory Care Services II: Use of Paramedics and Protocols for Selected Ambulatory Care Medical Problems"

Principal Investigator/
Institution: Herbert Sherman, D.E.E.
Anthony L. Komaroff, M.D.
M.I.T./Lincoln Laboratory
and Beth Israel Hospital
Boston, Massachusetts

Research Objectives and Design: The objectives of the Ambulatory Care Project were to provide a number of tools (protocols, training manuals, introductory material) that would permit physician extenders (health assistants, physician assistants, nurse-practitioners) to assist physicians in dealing with the most common causes for a patient encounter with the health care system.

Eleven prospective controlled studies have been conducted in eight different medical settings involving over 3500 patients. These studies have been performed at the Beth Israel Hospital Ambulatory Care Center, Boston City Hospital, Fort Richardson, Alaska, Harvard Community Health Plan, Kaiser Permanente Clinic in Inglewood, California, and the UCLA Student Health Service.

Summary of Findings: The Ambulatory Care Project has developed protocols for symptoms of acute presenting illnesses and for chronic diseases which account for approximately 50 percent of the one billion visits per year for ambulatory care.

The development of each protocol involved an intensive review of the medical literature, consultation with experts in the disease area and with other physicians in primary care practice. During this process, each protocol went through several revisions. A validation study was then performed. Typically, this study involved the random allocation of patients with a particular medical problem in an "experimental" group in which they were cared for by the new practitioners guided by the protocols with available physician consultation, or into a "control" group in which they were managed only by physicians. Thoroughness of the recorded evaluation, accuracy of presumptive diagnosis, relief of symptoms, expressed patient satisfaction, and the development of unrecognized serious illnesses were evaluated by medical record review and telephone follow-up; the quality of care in every study, as reflected by these measures, was equivalent in the experimental and control groups. Time-motion studies were conducted to evaluate the time spent by the new practitioners, the physician and the patient in the experimental and control groups. Depending upon the medical problem being addressed, a physician time-saving of between 20 and 90 percent was achieved in the experimental system. Cost of care--as a function of manpower time, medications ordered, and laboratory tests ordered--was equivalent or less in the experimental system.

IV. Project Title: "MUMPS Standardization Project"

Principal Investigator/
Institution: Mr. Seymour Jeffery
National Bureau of Standards
Gaithersburg, Maryland

Research Objectives and Design: MUMPS is an acronym for the Massachusetts General Hospital Utility Multi-Programming System developed under NCHSR's Research Grant No. HS-00240. As a high level, interactive language specifically designed to facilitate the creation and manipulation of text-oriented, hierarchial data, MUMPS quickly became the language-of-choice for developers and researchers investigating health care delivery problems. Unfortunately, each new implementation resulted in a new "dialect" of MUMPS, and useful medical application programs developed in one institution could not be transferred to another institution. The standardization effort was undertaken by NCHSR to slow the proliferation of MUMPS dialects and facilitate the exchange of programs of demonstrated value. Working with the National Bureau of Standards, the NCHSR assembled a MUMPS development committee composed of over 50 of the leading industrial, academic, and government implementers of MUMPS systems, and element by element constructed a super-set "MUMPS Language Standard" from the many dialects.

Summary of Findings: The "MUMPS Language Standard" was developed to enhance the exportation of good research beyond the developing institution. Its impact on the entire medical computing community (both research and service) will be toward reducing the spiraling costs of software development and implementation. The Standard is already being specified in contract and grant supported activities sponsored by government, academia and the private sector. Over 300 MUMPS program have been written, addressing the medical record-keeping aspects of health care, as in automated medical history taking, problem-oriented medical records, outpatient scheduling and census, intensive care unit medical records, and clinical laboratory data management. Included are programs for drug interaction, blood donors and blood bank data management, tumor registries, neurological and cardiovascular patient histories, and multiphasic screening. Programs have been written to assist the paramedic, provide the physician with needed consultation, instruct the patient, and teach the medical student. The MUMPS Language Standard is supported by four related NCHSR produced documents, a Primer for learning MUMPS programming, a Documentation Manual, a Reference Manual for advanced programming, and a set of Portability Requirements to insure "MUMPS" portability.

V. Project Title: "Hospital Effectiveness Demonstration Projects"

Principal Investigator/
Institution: Gordon R. Cumming
Hospital Educational Foundation
of California, Inc.
925 L, Suite 1250
Sacramento, California

Research Objectives and Design: The grant's overall objective was the development of a hospital financial reporting system which would enable fair comparison of diverse hospitals and serve as a model for statewide hospital financial disclosure mandated by a California law.

Summary of Findings: (1) The project substantially influenced implementation of the California Hospital Disclosure Act. A uniform financial reporting system was developed, tested, and accepted for hospital reporting. (2) Forecasts of demand for hospital services were generated which implied a worsening occupancy situation in California in general and in selected metropolitan areas in particular. (3) Comparisons of California with other U.S. hospitals indicate that California hospitals appear to have experienced higher costs and less utilization than have U.S. hospitals in general. Further analyses of cost and utilization data suggest that California patterns of medical practice place a greater emphasis on the substitution of ambulatory care for inpatient care. (4) Hospitals costs were analyzed by specification and estimation of cost functions controlling for service mix and case mix. Results indicate that both service mix and case mix must be controlled, or the cost functions will be seriously biased. For example, cost functions estimated without case mix variables suggest a positive relationship between cost per case and number of discharges; when case mix variables were controlled, constant returns to scale relationship were implied. In other words, when case and service mix complexity in a hospital is greatest, cost per case is greatest; when complexity is low, cost is low. (5) The study concludes that effective and equitable regulation of hospitals must be based on a sound, comprehensive data base and on appropriate methodologies.

Mr. FLOOD. Now, over the years your Center has supported technology research. Has any of that research provided to be cost beneficial? Where is that being applied outside of the test sites, now?

Dr. ROSENTHAL. Probably the easiest one to share with you is the use of computer methods to read electrocardiograms. That technology was developed by the National Center. Our estimate is that last year 14 million electrocardiagrams were read by computer. Our best estimate is that even with such followup readings, the average cost was somewhat under $5 a reading. I don't know what they cost otherwise, but the last one that came up on a laboratory bill for me where the cardiologist read it was about $27. So the difference is significant.

Mr. FLOOD. And another one?

Dr. ROSENTHAL. Another example of application of research findings is in the use of medical information systems. The National Institutes of Health have just bought a large-scale medical information system which they selected competitively as being the most cost effective. The system was developed and supported by the National Center for Health Services Research.

### THE ROLE OF THE NATIONAL CENTER IN DISSEMINATING RESEARCH RESULTS TO THE HEALTH SERVICE DELIVERY SYSTEM

Mr. FLOOD. Doctor, believe me, all last week we have listened to a number of witnesses here, just like the litany of the saints, identifying many, many, many of these problems. We have talked here for hours and days about the United States ranking 15th in infant mortality worldwide and about the very low immunization levels for certain specified segments of the poulation. We have talked about improving greatly communications between NIH and the practicing physician that delivers the services.

Now is this National Center for Health Services Research looking at all the ways that you can use all these available resources?

Dr. ENDICOTT. Well, sir, with the resources available we are doing the best we can, yes, sir.

Mr. FLOOD. But if you are not doing it now, what is your planning in the future? There are four or five things that have stood out over the last 2 weeks.

Dr. ENDICOTT. I think that the Health Resources Administration has a major responsibility in the years ahead in accelerating the translation of research results to the way medicine is being practiced across the country. Our best device for doing this is the new health planning system wherein the State agencies and sub-State agencies will interface with the health service delivery system, and to a considerable extent influence its resource development planning and operation.

What I am examining at the present time is some systematic approach whereby the Institutes of the NIH can provide us in the Health Resources Administration with their best advice as to what new things are ready for application across the country. We would then communicate this through the planning system to bring them into practice as quickly as possible. If there is some additional applied research and development that still needs to be done that doesn't naturally fall within the arena of the NIH, then we would propose to carry out that research and development in or under the auspices of, the National Center for Health Services Research.

DETERMINING HEALTH MANPOWER NEEDS

Mr. FLOOD. All right.

Now in another area that this committee has to wrestle with, there is a veritable mountain of conflicting testimony we get regarding health manpower needs. I don't mean just physicians. But all kinds of health manpower, the whole thing. Are you working on developing any kind of a mechanism to identify what are our current and future manpower needs and which areas are oversupplied and which areas will have shortages?

Dr. ENDICOTT. Yes, sir, we are. We will continue to do so. This is a joint effort involving the Bureau of Health Manpower and the National Center for Health Statistics. I regard it as a very high priority area. We have repeatedly come before this committee requesting funds to support this kind of activity. I think we are in reasonably good shape with regard to a few professions. Our data are best in medicine and they are pretty good in the field of dentistry.

Mr. FLOOD. What about paramedics generally?

Dr. ENDICOTT. That area, from a data standpoint, is very soft. It will probably continue to be so for many years to come. It is attributable in part to the fact that there are at least 100 different occupations in that rubric. They are trained in three separate kinds of institutions, universities, community colleges, and hospitals. Our ability to gather accurate data diminishes from the university to the community college. The data on people trained who get diplomas or certificates or the like from hospitals is very poor.

COOPERATION IN DATA ACTIVITIES WITHIN THE PUBLIC HEALTH SERVICE

Mr. FLOOD. Tell me, how do you work with the National Institute for Occupational Safety and Health? There has been a lot of attention in the last year or two in helping them identify manpower requirements in their own respective areas.

Mrs. RICE. Both the Occupational Safety and Health Administration and the National Center for Health Statistics conduct essentially data collection and analysis and these two programs work together on areas of common interest, for example, there is no question that there is a relationship between occupation, illness and causes of death, and we are both working together in this area.

Mr. FLOOD. And with NIH, too?

Mrs. RICE. Yes. We would like to be able to work more closely with them. If we get our request for reimbursable slots that we are asking for, we will do additional collaborative studies with NIH and with the Occupational Safety and Health Administration as well as with many other Federal agencies.

Mr. FLOOD. That is good.

Mrs. RICE. The National Center for Health Statistics has the capability for providing tabulations and analysis for data of all sorts, particularly on deaths by occupation. But the occupational data on the death certificates are really not that good. We need to go back and get more information on the basis of follow-back surveys on people who die because we do know that the data on occupations on the death certificate is not comprehensive enough. For example, a death certificate lists only the most recent occupation of an individual.

HEALTH SERVICE RESEARCH CENTERS

Mr. FLOOD. Now you also state in your justifications that you intend to establish 10 Health Services Research Centers. What do you hope to achieve with those Centers?

Dr. ENDICOTT. Several things. I would want Dr. Rosenthal to comment on this, too. The most important thing is my view for the Center concept is to create, in a limited number of university environments, a critical mass of the mixed talent from different scientific disciplines necessary to do the major complex studies needed in this area.

Most universities, for a variety of reasons, have never put together that critical mass of people. Once that is accomplished, they cannot only do important research, but they can also serve as sources of new research manpower, because they are in a university setting and can train people.

Mr. FLOOD. Do you have anything to add to that?

Dr. ROSENTHAL. I think that in each case when we designed a program we emphasized the obligation of the people in the Research Center to be available to the people in their area who use the research results, to people who provide services, and to those who need to have access to the researchers' findings.

DIFFERENCES BETWEEN THE RESEARCH CENTERS AND THE PLANNING CENTERS

Mr. FLOOD. I realize that but 10 of them? Why can't you merge those Centers with the 10 Planning Centers that are being funded under our health planning program?

Dr. ROSENTHAL. I think the answer is that they are in a different business.

Mr. FLOOD. That is what I am asking you.

Dr. ROSENTHAL. The Research Centers are exactly that. They do research. They provide settings for undertaking research. They are linked to service providing setting for research purposes. The Planning Centers are really technical assistance settings and are there to provide support and assistance to the operating planning agencies in executing their obligations.

Mr. FLOOD. The argument we get about this on the floor is that we have 10 centers for research and 10 centers to research the researchers. On this research business I remember we ran a test at a certain hour and certain day in a certain number of medical schools picked geographically throughout the country at 10:55 in the morning in freshman classes in medical schools to find out how many of the faculty were in there talking to those first-year medical students. About 95 percent were being conducted by senior medical students. The professors were upstairs in the laboratories.

We run into this all the time.

Dr. ENDICOTT. In this particular area you can turn the question back onto the questioners. There are two separate pieces of legislation which both mandated the Centers. The planning legislation mandates the Planning Centers and the research authorization mandates the Research Centers. So in part we are doing this because Congress told us to.

Mr. FLOOD. That is a good answer. I couldn't think of a better one myself. That is praise from Caesar.

NURSE TRAINING PROGRAM

Now I have told you before, time and time again, I learned the hard way, never turn your back on a nurse. Will you give us the rationale you had for eliminating both the nurse capitation grants and the nurse traineeships out of this budget? Why? How come? Give me nine good reasons for that.

Dr. ENDICOTT. I will be straining to get you one.

Mr. MILLER. Because we have recommended it nine times before, Mr. Chairman.

Mr. FLOOD. Let me ask you this: What is going to be the impact on the schools of nursing if we are to accept this budget for nursing now? What will be the impact on the schools?

Dr. ENDICOTT. It would have an adverse effect.

Mr. FLOOD. Yes, I know, but what will the effect be? Do you want me to tell you? There is going to be an increase in tuition, isn't there? Sure there is. That is the first big thing, increase the tuition.

Dr. ENDICOTT. That is certainly one alternative they have. Another is to turn to some other source of support, sir.

Mr. FLOOD. Now you are asking for an increase in advanced nurse training and for the nurse practitioner program.

Dr. ENDICOTT. Yes, sir.

Mr. FLOOD. How will the training supported by those programs differ from the training provided by the nurse traineeship program? Do we need both of these? If we don't, why not?

Dr. ENDICOTT. The nurse practitioner program provides grants to plan, develop, operate, significantly expand, or in some cases maintain programs for the training of nurse practitioners, for example, pediatric or geriatric nurse practitioners, nurses who will accept a role in large part representing a delegation of tasks from the physician. The advanced nurse training program is to establish programs designed primarily to train nurses for teaching and leadership roles—for example, to become the chief nurse of a hospital. The nurse practitioner and advanced nurse training programs provide assistance to institutions. Traineeship funds, on the other hand, are a form of student assistance that would go to the participants in these programs.

Mr. FLOOD. Do we need both of them?

Dr. ENDICOTT. Yes, sir, we certainly do need the nurse practitioner and advanced nurse training programs to provide more training opportunities. No traineeship funds are included in the budget because persons in these advanced training programs may obtain such assistance as guaranteed loans from the Office of Education, and upon completion of the training, stand to improve their incomes.

NURSING STUDENT LOAN PROGRAM

Mr. FLOOD. Now there is also a very substantial reduction here in the nursing loan program. Why is that reduction necessary?

Dr. ENDICOTT. This is part of the administration's proposal to phase out special health manpower loan programs and utilize the student aid programs of the Office of Education.

Mr. FLOOD. What is the impact of that kind of action on the students? Don't we have a prior commitment here under all the circumstances as well as we had to make new loans?

Dr. ENDICOTT. The budget is constructed to provide loans for students already in the pipeline, those who have already had loans.

Mr. FLOOD. I know but don't we have to meet the prior commitments as well as make any new loans?

Dr. ENDICOTT. We are not proposing to make new loans. We are proposing simply to honor the prior commitments.

Mr. FLOOD. Suppose you put in the record a table like the one that appears on page 742 of last year's hearings. Now that table shows the amount of loans that were awarded from loan collection, if you know what I mean. We want the 1975, 1976 and 1977 figures all shown on those tables.

Dr. ENDICOTT. All right, sir.

[The information follows:]

LOAN COLLECTIONS

Loan collections are pooled and used in combination with appropriated funds to make student loan awards. The estimated number of new loans for Health Professions and Nursing students obtained with funds collected would be as follows for 1975, 1976 and 1977:

| | 1975 | 1976 | 1977 |
|---|---|---|---|
| Health professions loans: | | | |
| Estimated collections | $11,400,000 | $13,800,000 | $15,000,000 |
| Number of new loans supported | 9,500 | 11,500 | 12,500 |
| Nursing loans: | | | |
| Estimated collections | $5,500,000 | $6,500,000 | $7,500,000 |
| Number of new loans supported | 6,875 | 8,125 | 9,375 |

NURSE CAPITATION FUNDS

Mr. FLOOD. If we restore the nurse capitation funds that are cut out in this budget, are you still going to need that $1 million for financial distress grants? That was quite a big thing a few years ago. Are you going to need that?

Dr. ENDICOTT. I would like to turn to Miss Scott.

Miss SCOTT. If capitation support is maintained to the schools of nursing, then the need for financial distress grants is considerably less.

HEALTH PROFESSIONS STUDENT ASSISTANCE

Mr. FLOOD. All right. Now for the health profession student loans the budget request is zero. Why in the world is that? I thought that we had to honor prior year commitments.

Dr. WHITESIDE. We have authority to honor previous commitments to students. We would be supporting these prior commitments from funds paid back to the institutions by previous borrowers.

Dr. ENDICOTT. Mr. Chairman, in this connection and at the risk of being chided when I get back to the office, I feel I should convey to you and to this committee my concern about the student aid picture in the schools of the health professions. I should note that this matter is under consideration by the committees of Congress working on the health manpower legislation, although as yet no bill has been reported out of committee. But everywhere I go I get the same story, that the schools find themselves in very difficult situations trying to meet the student aid requirements and that this is adversely affecting the mix of students that they are able to accommodate. The lack of funds

in the student aid area is causing the schools to select students whose family income level can sustain the higher costs of medical education. We are pricing the low-income students out of the schools.

Tuition is going up. The private loan market, even with guarantees, is bad for student loans. I hear the story everywhere. Every dean I have talked to in the last 6 months tells me the same thing. We are operating for the second straight year on a continuing resolution in the health manpower area. We need authorizing legislation. I do hope that the Congress in its deliberations will carefully consider this matter because I would hate to see medicine become a rich man's game.

DENTISTRY PROGRAMS

Mr. FLOOD. All right.

Now we don't see any specific requests in this budget for dental health activities. Have you decided that program is no longer needed?

Dr. ENDICOTT. No, sir. That is a budget technicality. It is carried in a different part of the budget.

Mr. FLOOD. In the record identify where that is, then, because last year you told us that the dental health program was absolutely essential with regard to dental education.

Dr. ENDICOTT. Yes, sir, it still is.

Mr. FLOOD. I mean dental practice, dental health research, dental manpower research. How are you going to accomplish all these things under this budget?

Dr. ENDICOTT. The activities of the Division of Dentistry are adequately taken care of in this budget but it is not a separate line item. We will be glad to identify that for you.

Mr. FLOOD. Yes; in some detail on that one.

Dr. ENDICOTT. Yes, sir.

[The information follows:]

DETAILED BUDGET—DENTAL PROGRAMS

| | 1975 | 1976 | 1977 |
|---|---|---|---|
| TEAM grants | $5,188,000 | $5,500,000 | $5,500,000 |
| Expanded function dental auxiliary | 1,700,000 | 1,700,000 | 2,000,000 |
| Educational contracts | 2,654,000 | 2,942,000 | |
| Program management | 3,055,000 | 2,350,000 | 2,700,000 |
| Subtotal | 12,597,000 | 12,492,000 | 10,200,000 |
| Capitation/basic | 31,800,000 | 24,469,000 | 29,400,000 |
| Special projects | 3,365,000 | 3,279,000 | |
| Primary dental care | | | 3,000,000 |
| Financial distress | 2,022,000 | | 500,000 |
| Loans | 7,165,000 | 4,080,000 | |
| General scholarships | 1,305,000 | 630,000 | |
| PHS scholarships | | 350,000 | 4,820,000 |
| Construction | 5,549,000 | [1] 28,392,000 | 0 |
| Total | 63,803,000 | 73,692,000 | 47,920,000 |

[1] From 1973 and 1974 carryover funds

DISSEMINATION OF DENTAL HEALTH INFORMATION

Mr. FLOOD. It seems that your whole dental program has a very substantial role to play in helping the National Dental Institute to disseminate their research findings. How in the world are you going to accomplish all of that under this budget?

Dr. ENDICOTT. As I have said before, this is a tight budget, but we are not proposing any serious reduction in the resources of the Division of Dentistry.

Mr. FLOOD. I understand but how are you going to do all those things you are talking about here under this budget regarding the National Dental Health Institute? That is a very important project disseminating that information. What are you going to use for money—rubber bands or cigar wrappers? How are you going to do that?

Dr. ENDICOTT. Because dental activities are not included as one generally looks at health manpower, it presents a special problem. The Division now called the Division of Dentistry, and which was previously called the Division of Dental Health represents HEW's principal resource in communicating with the dental profession and with the dental schools. About 2 years ago the Public Health Service established a special Dental Affairs staff office in the Office of the Assistant Secretary. It is headed by the former Director of the Bureau of Health Manpower, Dr. John C. Greene, who serves also as Chief Dental Officer of the Public Health Service. Dr. Greene's office, plus the Division of Dentistry, represents our principal communicating device over and above what is used by the National Institute for Dental Research.

Mr. FLOOD. You are making it tougher to answer my question. How are you going to do this with this budget?

Dr. ENDICOTT. Not very well.

Mr. MILLER. Could I make two points? I think there ought to be two things in the record in connection with what Dr. Endicott has been talking about. One, in the health manpower legislation which Dr. Endicott is urging be enacted we have a recommendation for a special scholarship program which would be targeted toward alleviating the specialty and geographic maldistribution problems and toward assisting students financially. The National Health Service scholarship program which which we are asking $35 million provides scholarships to medicine and dental students in exchange for a specified period of Federal service. Secondly, you appropriated $8.4 million for dentistry which we will be spending in fiscal 1976. The comparable figure is $5.5 million in fiscal 1977.

Mr. FLOOD. Utilized for the purpose of dissemination of information?

Mr. MILLER. Dr. Endicott would have to say how the total amounts would be spent. I assume part of it is available for that.

### SLIPPAGE IN IMPLEMENTING THE PLANNING PROGRAM

Mr. FLOOD. Mr. Natcher?

Mr. NATCHER. Dr. Endicott, last year when you appeared, I believe you informed the committee that the health system agencies would be in place by December 31, 1975. What has caused you to miss your target as far as your original date is concerned?

Dr. ENDICOTT. I think the principal factor, and Mr. Rubel ought to correct me if I am wrong, is that we lost several months in developing the regulations. We will have them all funded by the end of June. So we slipped about 6 months. The process of issuing regulations is very complicated. We have slipped a little, but I think Mr. Rubel's

track record in moving regulations along is brilliant. It is better than anything I have seen recently in the regulation area. Mr. Rubel?

Mr. RUBEL. Mr. Natcher, we are 3 months behind. We expect to have, I would say, somewhere between 125 and 150 of the health system agencies designated and funded by the end of this month. We did not anticipate the enormous controversy and interest surrounding this law. It has taken us a little bit longer than we had expected, but not very much longer. We have protected the existing comprehensive health planning agencies, the regional medical programs, and the experimental health service delivery systems and have given them funds to keep them going during this extra 3 months.

Mr. NATCHER. What is the impact of this slippage on the implementation of the balance of the program?

Mr. RUBEL. I don't believe that it is of enormous significance.

Mr. NATCHER. Doctor, you are not requesting funds for the medical facilities construction program. Why?

Dr. ENDICOTT. The reason is that until these new planning agencies we were just talking about are operational and have developed plans against which requests can be evaluated, we could not spend the money anyway. It is really built into the law.

### MATCHING FUNDS FOR HEALTH SYSTEMS AGENCIES

Mr. NATCHER. Are the health systems agencies entitled to receive funds other than Federal funding?

Dr. ENDICOTT. They are not entitled to other funds but they are authorized to accept some matching funds.

Mr. NATCHER. What is the source? Can you give me the source now of any of your matching funds?

Mr. RUBEL. They are allowed to receive funds from any public source, from State or local government. Private funds cannot come from any institution that is involved in the delivery of or research into health care, but funds such as United Way funds would be acceptable. Private donations, and perhaps funds from corporations, as long as they are not involved in the delivery of health care, would be accepted.

Mr. NATCHER. Can you give us an idea as to approximately how many you expect to receive in fiscal 1977?

Dr. ENDICOTT. It would just be a guess.

Mr. RUBEL. That is right. We are still not sure at all. We expect that there will be something in the order of $9 or $10 million that agencies will use to request matching from us. The law allows for a 25-cent per capita as long as it is matched with local money. As far as fiscal 1977 is concerned, that would be very hard to determine.

### RATE REVIEW

Mr. NATCHER. The health planning budget requests $2 million for rate review projects. How successful have these rate review activities been up to this time?

Mr. RUBEL. It is fair to say there are only a very small number of States that have directly regulated rates, primarily of hospitals. I think it is fair to say that in New York there is some evidence that it has been fairly successful. I heard last night that in the State of Connecticut they feel they have reduced the rate of increase in health care

costs for hospitals by one-third in the last 3 years because of their direct rate review activities. In general, we are all experimenting across the country and the States are really only now beginning to think about the desirability of regulating hospital rates.

Mr. NATCHER. With the rising rate and cost as far as medical care is concerned, shouldn't we be expanding this kind of an activity?

Mr. RUBEL. Mr. Natcher, the Congress in enacting section 1526 of the Public Health Service Act called for an experiment and for demonstrations in up to 6 States. The administration had requested authority to deal with any State that was willing to get into rate review. I suspect that would still be the administration's request. I think it is fair to say between the authority that we have here in section 1526, and the research authority in the Social Security Act, section 222 of the 1972 Social Security Act Amendments, we will be able to fund all of the State activity that is there. In other words, all States that are interested will receive funds. Perhaps in the future this is something the Congress would wish to look at again.

LONG-TERM CARE RESEARCH

Mr. NATCHER. With regard to health services research, I notice that you are conducting studies on long-term care. Doctor, how do you involve the other agencies of the Public Health Service in this endeavor?

Dr. ROSENTHAL. The long-term care interests and responsibilities are, as you know, widely spread throughout the Department. We have primarily had two activities within the National Center for Health Services Research, the basic research and demonstration activities and the short-term training activities. The latter activities are no longer our responsibility. They are now housed at the Administrator's level of the Health Resources Administration.

In the research enterprise, we have developed basic research in conjunction with SRS, SSA, the Administration on Aging, and other parts of the Department that express some interest. We widely circulate our research objectives and aims and deliberate with those other organizations in developing our research agenda, often sharing the costs of such research activities.

Mr. NATCHER. What have you learned through your long-term care studies that would help this committee?

Dr. ROSENTHAL. One thing is that many different things show up under the guise of long-term care. In terms of deciding how to invest resources in the service providing system, it is clear that we have not done a very good job in differentiating among the needs of different kinds of patients. The National Center for Health Services Research has developed over the last few years a patient assessment instrument which has been applied in a number of long-term care settings. Although we have no definitive assessments, we have just recently completed an analysis of the implications of placing patients in the least costly facility appropriate for their medical and service needs. That study is not definitive, but the early projections we have generated suggest that for the group we have looked at, covering a population in the Rochester area of upstate New York, that savings of 10 to 20 percent in the cost of care were generated by having a systematic way of placing people in the most appropriate and effective setting. So, that is one area where we believe we really know a lot more than before. I think that is tremendously important.

COORDINATING DATA NEEDS OF THE PLANNING AGENCIES

Mr. NATCHER. Last year we talked about the health planning agencies needing health statistical data in order to function properly. Will the National Center for Health Statistics be able to provide the planning agencies with this data, or will the agencies establish separate statistical data systems?

Dr. ENDICOTT. It is our hope and expectation that at the State level, the various interested parties, including State government, HSA's, the hospital associations, and others, will form a consortium and designate a single responsible institution or organization to be the repository of the data, and that the National Center of Health Statistics and the Bureau of Health Planning and Resources Development will be able to interact primarily with that single agency so that the data can be pooled and shared. To a large extent, the National Center for Health Statistics through the Cooperative Health Statistics System will be able to provide the data they require. To some extent they will not.

Mr. NATCHER. What do you have now, about 210 or 211 separate agencies collecting and producing this data for you? Is that about the number?

Dr. ENDICOTT. It would be risky for me to try to answer that. It is a complicated picture as to where all the data come from. I would like to pass that question to Mrs. Rice.

Mrs. RICE. I believe there are 211 health systems agencies which will be designated under the health planning legislation. The agreement between the Bureau of Health Planning Resources and Development and the National Center for Health Statistics provides for building on existing systems and for these agencies to obtain their data through the cooperative health statistics system whenever possible. However, if we are not able to implement this system, then these health systems agencies and many other Federal health programs will be forced to develop their own independent data systems. Our goal within the resources that we do have is to try to respond to the needs of the health systems agencies as well as to the needs of many other programs.

Dr. MARGULIES. If I may, this refers to some of the earlier questions on the cooperative health statistics system. We do have a clear agreement which means that anyone who collects data at the State or local level will, wherever possible, do it in a manner which fortifies the health data collection system. The sooner we can get that system into place, the greater the level of consistency we can have, and the more rapidly these agencies will have the information they need.

The point is, as was mentioned earlier in the discussions, that the planning agencies will need data and will be collecting data, and it will be costly in many cases and sometimes it will not be the kind of data they need, which is all the more reason to work toward the kind of cooperation and uniformity which we cannot otherwise get.

Dr. ENDICOTT. We have a working model that is highly successful in the State of Rhode Island. It was spun off from the Rhode Island Health Department, and is now operated by a private corporation called Search. They have done a remarkable job of data pooling, sharing, analysis, and of serving multiple purposes. It serves the State health department, planing agencies, the State hospital association and others. I think it will function and play a major role in PSRO. They have debugged the system pretty effectively. It is my hope and ex-

pectation that modification of this approach will be established in all 50 States, which will be enormously helpful.

Dr. MARGULIES. I would also like to point out that the activity in Rhode Island is the direct product of the two centers represented at the table.

CENTRALIZATION OF DATA COLLECTION

Mr. NATCHER. Would it be better to have a centralized unit established as far as the collection is concerned?

Dr. ENDICOTT. This is a problem with which the Department is currently wrestling. At the moment, what has been established is a departmentwide health data coordinating committee. Within the Department there are several major data collecting activities. One, of course, is the National Center for Health Statistics. The other major activity is in the Social Security Administration. That is the program which was previously headed by Mrs. Rice before she moved to her current job. Whether it would indeed be most effective to put them all under the same management is something which is being actively investigated. My inclination is to say that probably it would be the more effective way to go, but I have not looked at this problem from the standpoint of the Social Security Administration. They may have some very good and very valid objections to this kind of consolidation, but we are making a strong departmentwide effort to pull together and coordinate and manage our various data-gathering activities.

Mr. NATCHER. Thank you, Doctor. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Patten?

THE SIGNIFICANCE OF COMPARATIVE HEALTH STATISTICS

Mr. PATTEN. Dr. Endicott, it may not be relevant, but we are going to be asked to vote in a few minutes on an International Security Assistance Act of 1976. Now that word "security" tips you off, right, international security? It is over $5 billion. That is $5,000 million dollars. We are going to give guns to the Middle East in terms of billions of dollars. So I am interested in your statistics in terms of foreign nations. You don't give us, when you speak of child deaths, any figures from Asia or any figures from behind the Iron Curtain. Your statistics show we are 17th, but you compare it to Holland, England, France. You don't give us any figures for the Ivory Coast. Don't they have figures? Aren't they reliable?

Dr. ENDICOTT. I would like to answer that question and then perhaps Mrs. Rice might want to supplement it.

The developing countries by and large have poor vital statistics. Nobody has the figures. They are not being concealed from us, they just aren't being collected. In the case of the Iron Curtain countries, based on my contacts with them as a delegate from the United States to various meetings behind the Iron Curtain, they do have good data but they don't elect to share it with us.

Mr. PATTEN. The chairman is horrified that we are No. 17 as compared with other countries. But for those with regular family life who get prenatal care and get into the hospital for supervision, I would say the rate for them is not one death out of 200. That is what a baby doctor tells me.

Dr. ENDICOTT. For middle and upper class people in the United States our infant mortality rates are excellent indeed. What drags

our figures down are the infant and maternal mortality rates of the low income and the disadvantaged.

Dr. MARGULIES. Mr. Patten, with the data in the book—"Health—U.S. 1975"—you will be able to determine that, because it contains information by income class and by education, that you can compare mortality rates for mothers and infants and for other kinds of incidences by those classifications. It is very readily available in the book as you go through it.

Dr. ENDICOTT. But what you have observed is certainly true. Our infant and maternal mortality figures look bad because they are bad in low income, disadvantaged, minority groups.

RESOURCES DEVOTED TO HEALTH STATISTICS

Mr. PATTEN. For what you spend to try to get us statistics about ourselves, how do you compare with how much money is spent to keep statistics about ballplayers? Here you ever seen the statistics on baseball?

Dr. ENDICOTT. I have seen the statistics but I have never seen their budget.

Mr. PATTEN. Would you want to guess that it is more than yours?

Dr. ENDICOTT. I would not be surprised.

Mr. PATTEN. My guess would be it is higher than yours because all the media want it and there is a market for it.

Dr. ENDICOTT. I am amazed at the statistics that the sports announcers are able to generate at a football game or a baseball game.

Mr. PATTEN. I think the cost to tell us where we stand and what we are paying, how it is divided and what happens in the country as a whole should not cause any great concern. The chairman tried to say that you are not going to sell many of the health reports. A couple of million "Cosmopolitans" are sold but you are not going to sell 2 million of these. There is no charisma in it.

Dr. MARGULIES. We wanted to change the cover but they won't let

IMPACT OF HEW FUNDS ON LOCAL ECONOMICS

Mr. PATTEN. Let me tell you about my experience. We are in a depression. Of the money you are handling in HEW, the township of Woodbridge received in the past 12 months over $100 million for medicaid, medicare, VA benefits, social security. My little town of 40,000—we always prized the few plans we had with $8 million programs, five of which are closed now—we received last year, according to my figures, $69 million, principally from HEW.

Mr. FLOOD. What committee are you on?

Mr. PATTEN. Military Construction. The point I am making is that HEW, in my community, is providing support that keeps us on our feet as compared to the 1930's. Were you to cut out everything out of the budget and get back to 1930 and not pour $100 million into Woodbridge in medicaid, medicare and social security, the banks would be closed and the merchants would be out of business. HEW is doing more to prevent a real depression than any other area of government. I think we ought to tell people about that.

Dr. ENDICOTT. Mr. Patten, I am very proud to be a part of HEW.

DRAWING VALID CONCLUSIONS FROM HEALTH STATISTICS

Mr. PATTEN. Well, one other question and I am going to quit because the chairman did an excellent job. He covered everything. He thought of everything I was going to say, he and the staff. The National Institute of Cancer issued an atlas with figures they gathered from 1951 to 1969 and claim I am living in the State with the highest rate of mortality for rectal and bladder cancer and cancer of the ovaries and our people think they are all going to die of cancer. That includes Mr. Flood's district, too. They draw a belt right up to Wilkes-Barre. I think it is a lot of baloney.

I would hope that more recent figures can come up wtih something beter for me so I can tell my people in 1975 and 1976 there is nothing about living in Wilkes-Barre or Perth Amboy that makes us have the highest mortality rate for rectal and bladder cancer.

I don't believe the atlas is valid and up-to-date. Will your computers help me?

Dr. ENDICOTT. I think I have bad news for you there. The atlas is based on Mrs. Rice's data. I am afraid you are in a high incidence area.

Mrs. RICE. Mr. Patten, the cancer atlas was prepared by the National Cancer Institute based on the data provided by the National Center for Health Statistics on mortality by diagnosis.

Mr. FLOOD. Are you speaking of cancer in the two areas he was referring to?

Mrs. RICE. It is an atlas that describes the high risk areas for cancer.

Mr. FLOOD. Are you talking about any particular kinds of cancer across the board or just the two kinds he was talking about?

Mr. PATTEN. I only included a few there. We got a bad report card.

Mrs. RICE. It was based on a compilation of the data over a period of some years.

Mr. PATTEN. 1951 to 1969.

PROPOSED CHANGES IN MEDICARE COVERAGE

Mr. PATTEN. Doctor, the President spoke to the Congress in the State of the Union. He addressed how he would improve health care, social security, and senior citizens programs. You have that in your justification. Who sold him that bill of goods? Most of the people in social security and most of the people I have talked with think someone misled the President on the state of the Union speech as to how they may be better off under his plan. You are using it in your justification. Are we ready to talk about it?

Mr. MILLER. You know that that is proposed under medicare and Mr. Cardwell will be up to testify in about a week. He will be glad to go over it with you in detail.

Mr. PATTEN. We can let it go until Mr. Cardwell comes in to testify. Maybe we will learn something.

I was under the impression that someone probably sold the President a poor bill of goods when he put that in his speech.

Dr. ENDICOTT. Sir, I am not a good witness to respond to that question. Mr. Cardwell is much more familiar with it than I am.

Mr. PATTEN. It's always a pleasure to see you.

Mr. FLOOD. Thank you very much, Doctor.

Mr. Michel.

Mr. MICHEL. Can we meet our manpower needs without expanding the supply of physicians, such as through redistribution, substituting paraprofessionals, et cetera?

Dr. ENDICOTT. The future manpower needs of the Nation cannot be met without an expansion in the number of physicians over the next decade or two. However, some lessening of the need for physicians can be accomplished through a number of developments, including increasing the productivity of physicians, task delegation of some physician tasks to lesser skilled manpower, increased utilization of aids, assistants, et cetera, and changes in the geographic and specialty choices of future medical school graduates. By the mid-1980's, it is anticipated that expected increases in the number of physicians graduating from U.S. medical schools and the continued immigration of foreign medical graduates to the United States will bring physician supply to its highest point in history and to a near balance with requirements for physicians.

Mr. MICHEL. You have a special program underway to get at the problem of the maldistribution of health personnel. Would you describe to us the specifics of this program, and tell us what it has accomplished thus far?

Dr. ENDICOTT. Actually, we have several efforts underway to address the problem of geographical maldistribution.

Area health education centers are designed as a system to link health service and educational institutions to serve both community and students with emphasis on clinical training in hospitals and ambulatory care setting in medically underserved areas. Our fiscal year 1977 request would increase these centers from 11 to 19 containing 48 sites and serving about 35,000 students.

Health professions and nursing educational loan repayment programs provide for the payment of 60 percent of professional education loans for 2 years service in a designated health manpower shortage area and 85 percent for 3 years. Between January 1975 and January 1976 some 661 practitioners benefited from this program, more than double for the previous 18 months.

Finally, the Public Health National Health Service scholarship program will soon be providing medical manpower for the National Health Service Corps and other PHS programs. These doctors will serve 2 or more years in critical health service shortage areas, on Indian reservations, in Federal prisons, and with the U.S. Coast Guard. As of June 30, about 2,600 recipients will be in the program. By the end of 1977 we expect over 4,650 medical and dental students will be participating. Our first graduates were placed in internships this past year.

Mr. MICHEL. What have your studies shown regarding our health manpower needs? Is there a real shortage, or is it mainly a problem of maldistribution?

Dr. ENDICOTT. Manpower shortages have traditionally been defined as the difference between supply and requirements. Although relatively accurate data exist on the supply of health manpower, requirements estimates are much more difficult to make, and vary substantially according to the concept used. One traditional approach for quantifying estimates of physician requirements has been to utilize "optimum" or "adequacy" ratios of manpower to population based on professional

judgment. On this basis, for example, one could estimate a shortage of 31,000 M.D.'s if it were assumed that all counties in the United States should have an M.D.-to-population ratio of 100 per 100,000 population. On the other hand, if it were assumed that all counties should have an M.D.-to-population ratio of 80 to 100,000, then the shortage would be less than 17,000.

On the whole, however, whatever shortages do exist are mainly reflections of geographic or specialty maldistribution. We will supply a table for the record showing the number of areas that are officially designated as shortage areas for health professionals for purposes of loan repayment or for placement of National Health Service Corps personnel.

[The information follows:]

HEALTH MANPOWER, NUMBER OF SHORTAGE AREAS AND PRACTITIONERS NEEDED

| Type of practitioner | Population to practitioner ratio | Number of shortage areas | Number of additional practitioners needed [1] |
|---|---|---|---|
| Loan repayments—HP: | | | |
| Physicians (M.D. and D.O.) | 1,500:1 | 1,953 | 8,677 |
| Dentists | 3,000:1 | 1,586 | 4,173 |
| Podiatrists | 25,000:1 | 1,345 | 2,196 |
| Optometrists | 15,000:1 | 870 | 1,257 |
| Veterinarians | 15,000:1 | 490 | 984 |
| Pharmacists | 4,000:1 | 192 | 328 |
| NHSC scholarships: | | | |
| Medical (primary care physicians, nurse practitioners, or physicians assts.) | 4,000:1 | 869 | [2] |
| Dental (general care dentists or dental aides) | 5,000:1 | 739 | [2] |
| Loan repayments—Nursing: | | | |
| Nursing shortage counties [3] (loan repayments) | | 531 | 5,171 |
| Nursing shortage hospitals (loan cancellation) | | 2,964 | [4] |

[1] The number of additional practitioners needed is computed as the number required to bring the population-practitioner ratio down to the level of the criterion used.
[2] Determined by regional office upon review of community applications.
[3] The list of nursing shortage counties, where service would qualify an individual for loan repayment benefits, is currently under review; publication is planned shortly. A shorter interim list is now in effect.
[4] No limit has been set for the loan cancellation program. Individual service must be certified by the State health authorities as meeting a shortage at the institution.

HEALTH RESOURCES RESEARCH

Mr. MICHEL. I note that you are budgeting $24 million for health services reseach. Is there any other research being done in your shop, or is that the extent of it?

Dr. ENDICOTT. Yes; some research is being done in the National Center for Health Statistics through the cooperative health statistics program and a limited amount in dental health in the Bureau of Health Manpower.

COOPERATIVE HEALTH STATISTICS SYSTEM

Mr. MICHEL. How is the cooperative health statistics system working out?

Mrs. RICE. The development of this system has worked quite well. The concept is sound, the research and developmental work has been successful, and the reception of the system by the States has been enthusiastic. The contracts we now have with States to provide us with data have been quite successful.

Mr. MICHEL. I understand Illinois was recently granted funds to pursue a project along this line. Are you familar with that project? Is it performing well?

Mrs. RICE. We did just recently fund a contract with Illinois through the hospital care component of the cooperative health statistics system. The purpose of this contract is to help Illinois develop a data system capable of providing the types of information needed by professional standards review organizations and others on the medical care received by patients in hospitals throughout the State.

Although this contract with Illinois has only been in effect for a little over 2 months we are quite happy with the enthusiasm displayed by the State and we fully expect a successful project.

I would also like to mention that we have another project with Illinois in the vital statistics component of the cooperative health statistics system. This contract has been in force since 1974 and the output from the State has been most satisfactory.

Mr. MICHEL. Funds have been requested by a number of different agencies such as NIH, ADAMHA, HSA, and so forth, for data collection services, management information systems, et cetera. I understand that the National Center for Health Statistics is to be the lead organization for collecting all health data. What is NCHS doing to get a handle on who collects what, so that the duplicative expenditures can be eliminated?

Mrs. RICE. The National Center for Health Statistics is the primary Federal statistical agency concerned with the collection of health data and we do have a legislative mandated responsibility for coordinating the collection of health data throughout HEW.

As Director of the Center I cochair the Health Data Policy Committee which oversees health data collection activities. In the past year this committee has developed two very important documents which are designed to help reduce duplication and provide for coordinated health data systems. The first of these was an inventory of data systems based on a thorough review of current health data collection efforts in the Department. After a review of this inventory and a consideration of policy issues a document entitled the "Health Statistics Plan" was developed. This document lays out the future responsibilities of the various agencies for collection and analysis of health data.

Also, as you are aware, the National Center for Health Statistics is now developing the cooperative health statistics system. Through this system we work with many other agencies to help meet their data needs.

I feel that through these two mechanisms we can make much progress in reducing redundancy of data collection, increasing the comparability of our data and reduce the reporting burden on respondents.

### HEALTH PLANNING

Mr. MICHEL. Regarding these new health planning areas, about how many of them do you expect to be in existence when the program is fully operational?

Mr. RUBEL. 202 health systems areas have already been designated. As you know, the law exempts the four territories and Puerto Rico from designation. In addition, the District of Columbia, Rhode Island, Delaware, and Hawaii applied for and received waivers to the designation process. The State agencies for these nine exempted territories and States will carry out the functions of a health system agency. So, in all, there will be a total of 211 areas eligible for health systems agency funding.

Mr. MICHEL. When will the program be fully operational?

Mr. RUBEL. We expect the program to be fully operational by June 30, 1978. By this time, all health systems agencies will have exhausted their maximum 2-year conditional experience and must then either become fully operational or be terminated.

Mr. MICHEL. What do you expect the total cost of the program to be when it become fully operational?

Mr. RUBEL. Mr. Michel, based on the functions to be carried out by the new agencies and previous experience with the existing agencies, about $94 million would be required. This is an average of about $445,000 per agency.

Mr. MICHEL. Your request would provide $385,000 per fully designated agency. What specifically would this money be used for by the agency?

Mr. RUBEL. These funds would be used to pay the salaries of personnel engaged in carrying out the functions of the health systems agencies.

Mr. MICHEL. Can you give us an item-by-item breakdown?

Mr. RUBEL. Yes, sir. I will supply that information for the record.

[The information follows:]

| Functions | Average agency | |
|---|---|---|
| | Estimated man-years | Cost |
| A. Organizational activities | 2.4 | $60,000 |
| 1. Governing body establishment. | | |
| 2. By-laws, agency policies. | | |
| 3. Agency management. | | |
| 4. Information. | | |
| 5. Training. | | |
| B. Planning activities | 3.1 | 78,000 |
| 1. Assemble and analyze data. | | |
| 2. Development of health systems plans. | | |
| 3. Development of annual implementation plans. | | |
| C. Interrelationships | 1.6 | 41,000 |
| 1. PSRO's. | | |
| 2. Evaluation review agencies. | | |
| 3. Cooperative health statistics systems. | | |
| 4. Other HSA's. | | |
| 5. Other planning groups. | | |
| D. State coordination | 2.1 | 52,000 |
| 1. State agency. | | |
| 2. Statewide health coordinating council. | | |
| E. Review activities | 2.7 | 67,000 |
| 1. New institutional services. | | |
| 2. Federal grant requests. | | |
| F. Support staff activities | 3.5 | 87,000 |
| Total | 15.4 | 385,000 |

## RESEARCH ON COST OF MEDICAL SERVICES

Mr. MICHEL. One of your research endeavors is to determine the reason for the rapid escalation in the cost of medical services over the past 4 years. What have you found out thus far?

Dr. ROSENTHAL. Several research grants and contracts supported by the National Center for Health Services Research have helped to document those characteristics of our health services industry which have contributed to accelerated inflation. These studies have complemented the research emphasis and findings of other agencies on the inflationary cost incentives embodied in the way we presently pay hospitals through third parties for full historical costs (retrospective reimbursement) and the incentives to use more expensive inpatient rather

than ambulatory care facilities as motivated by provider interests and health insurance provisions. I will be happy to submit a list of our findings to date for the record.

These results, together with ongoing research on factors affecting service intensity and physician payment mechanisms and productivity, are a subset of other major findings which relate to primary issues of concern under national health insurance. These findings, which trace out the expected inflationary impact of NHI, have been detailed in my recent testimony before the Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, House of Representatives.

Research findings concerning escalation of cost of medical services:

1. Increased demand for hospital care has led to the offering of a more technologically sophisticated, and more expensive, hospital product. Hospital wages have also evidenced a dramatic catchup in the recent past. Contributing factors have been existing biases in existing health insurance and the increasing emphasis on defensive medicine (M. Feldstein).

2. Changes in treatment of selected illnesses, that is, appendicitus, maternity care, myocardial infarction) have tended to be cost-raising, that is, costs have risen more than they would have if prices only had changed (Scitovsky).

3. An increase in collection ratios and/or decrease in free care to the elderly by physicians has been associated with Medicare Supplemental Insurance Benefits (Sloan).

4. Existing insurance is heavily biased in favor of surgical and in-hospital procedures (Sloan).

5. The quantity of services provided per physician appears to decline as prices increase, suggesting that physicians will trade off increased revenue for greater leisure time (M. Feldstein).

6. A comparison of the usual—customary—reasonable (UCR) and traditional fee schedule methods of reimbursing physicians indicates that UCR, used by most private health insurance plans, results in both higher fee levels and faster rates of fee inflation (Sloan).

7. Use of extended care facilities tends to complement rather than substitute for treatment at short-term hospitals, coverage of ECF's is associated with increased episode and program cost (M. Feldstein).

8. While hospital costs increased faster than the consumer price index during 1964–73, inflation did slow appreciably during the period of Cost of Living Council (COLC) regulations. The extent to which this can be ascribed to COLC is not entirely clear, however, since the decline in the hospital inflation rate started in 1970 before COLC was established (Lave).

9. Although certificate-of-need laws have successfully curbed bed expansion, such laws have also prompted hospitals to accelerate their costly investment in services, facilities, and equipment. Such programs may tend to increase hospital inpatient costs per day while days and admissions per capita have been reduced (Salkever).

Mr. MICHEL. What has been the nature of your research in the health insurance field?

Dr. ROSENTHAL. As documented in detail in our recent testimony to the Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, House of Representatives (Feb. 10, 1976), the empirical research supported by the National Center for Health Services Research has done much to clarify some of the

uncertainty around major issues concerning health insurance. All of the studies supported by the National Center are directed at helping to array the alternative outcomes of a policy measure before its enactment. National Center funded studies which have examined the price elasticity or responsiveness of demand for health services, the distributional aspects of national health insurance benefits and finance, the efficacy of regulatory activities to control inflation, and the impact of insurance on provided price and output decisions have added to our understanding of the implications of various proposals.

Specifically, our studies in the form of grants and contracts fall into three major groups. The first might be called the Demand Response to NHI and is comprised of several research activities which empirically address the factors which can differentially affect the consumption of, and ability to pay for, various health services. These factors include the impact of net money prices on demand, the effect of coinsurance and deductible, the effect of waiting and traveltime, and the impact of other nonfinancial barriers to access. A second set of issues dealt with by National Center supported research can be categorized as Supply Response to NHI. A number of studies have examined the potential impact of health insurance on provided behavior with respect to production and pricing decisions. A final set of research has focused on what might be termed Regulatory Response, and these studies deal with the effectiveness of programs designed to control health service price and cost inflation.

These studies indicate that a national health insurance plan, with deductibles and coinsurance, will still have an inflationary impact on the health services system, especially in the case of ambulatory care; regulatory mechanism have not been successful in curbing this inflation in the past. Ongoing studies which are addressing issues such as the impact of adverse economic conditions on health insurance coverage, various aspects of catastropic insurance, and collaborative demonstration research on adult day care will add to the analytical framework and knowledge which the National Center for Health Services Research has helped to generate.

### DISSEMINATION OF RESEARCH FINDINGS

Mr. MICHEL. Have you begun an increased dissemination of your research findings as yet, and if so, what does it entail?

Dr. ROSENTHAL. Efforts to improve dissemination of our research findings are underway. They include a requirement that all grantees and contractors submit at the conclusion of a project an executive summary which will be used to disseminate the research results of that particular project; major revision of the National Center's mailing list is underway; we are stimulating conferences designed to inform potential users of NCHSR sponsored research findings; we hope to establish a centralized clearinghouse operation for providing information on research findings modeled after the BHPRD National Health Planning Information Center.

### PEER REVIEW PROCESS

Mr. MICHEL. Are these research grants approved through the peer review process, or is there some other mechanism?

Dr. ROSENTHAL. The National Center for Health Services Research is mandated under Public Law 93–353, "Health Services Research,

Health Statistics, and Medical Libraries Act of 1974" to submit each application for a grant or contract in an amount exceeding $35,000 of direct costs and for health services research, evaluation, or demonstrations project to a panel of experts appointed from persons who are not officers or employees of the United States and who possess qualifications relevant to the project for which the application was made.

Mr. MICHEL. How many separate peer review panels do you have?

Dr. ROSENTHAL. The National Center for Health Services Research has three peer review panels. These are the Health Services Research Study Section, Health Services Developmental Grants Study Section, and the Health Care Technology Study Section.

Mr. MICHEL. About how many grants on the average do they review and approve?

Dr. ROSENTHAL. For the calendar year 1975 the Health Services Research Study Section reviewed a total of 114 research grants and approved 24; the Health Services Developmental Grants Study Section reviewed 195 research grants and approved 33; and the Health Care Technology Study Section reviewed 47 research grants and approved 7.

Mr. MICHEL. Who selects the members of these panels?

Dr. ROSENTHAL. The members of the three study sections are selected through the joint efforts of the Executive Secretary for each study section and the Director of the National Center. The Executive Secretary receives input from other study section members, the chairman, National Center staff, and from his own personal knowledge of health services researchers.

Mr. MICHEL. Where do the individuals selected normally come from?

Dr. ROSENTHAL. The selected individuals come from academic institutions and nonprofit health services research organizations.

Mr. MICHEL. Is there any basic criteria used to govern the selection of these individuals?

Dr. ROSENTHAL. During the selection process there are several distinct criteria utilized. First, members are selected from recognized leaders in the respective disciplines. The compositions of the study sections as to disciplines is oriented to the types of research grant applications the study section reviews. Other criteria utilized relate to the geographical location with full consideration for proper percentage of representation of women and minorities.

Mr. MICHEL. Do any of these individuals sit on more than one panel?

Dr. ROSENTHAL. No. Under existing DHEW Committee Management regulations no individual can be a member at the same time of two advisory committees whose function is to review research grant applications.

Mr. MICHEL. What kind of reimbursement do they receive?

Dr. ROSENTHAL. Each member is compensated at the rate of $100 per day for time spent at meetings. They are also reimbursed in travel costs and receive up to a maximum of $33 per diem in lieu of subsistence expenses. The $33 per diem applies to any travel in the United States except those areas designated as "High Rate Localities." Expenses in those areas will be reimbursed on an actual and necessary basis up to the maximum specified.

Mr. MICHEL. I think you ought to provide for the record your most recent list of review panels and the names of the people, and institutions they come from, who serve on each panel. Also indicate the dates they met and total number of grants they approved on those dates.

Dr. ROSENTHAL. Yes, sir, I will be happy to submit that for the record.

[The information follows:]

National Center for Health Services Research

HEALTH SERVICES RESEARCH STUDY SECTION

ROSTER—JANUARY 1976

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HEALTH CARE TECHNOLOGY STUDY SECTION

JANUARY 1976

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MEETINGS AND APPROVAL RATE

I. Health Services Research Study Section met three times during 1975: January 12–15, when they approved 8 grants; April 9–11, when they approved 9 grants; and September 18–19, when they approved 7 grants.

II. Health Services Developmental Grants Study Section met five times during 1975: January 15–17, when they approved 7 grants; April 23–25, when they approved 11 grants; June 17–19, (this was the initial meeting for Health Services Research Centers where the study section took two actions, disapproval and deferral for site visit); August 13–14, when they approved 14 grants (this was the final meeting for HSR Centers); and September 8–10, when they approved 1 grant.

III. Health Care Technology Study Section met three times during 1975: January 20–21, when they approved 1 grant; April 21–22, when they approved 3 grants; and September 22–23, when they approved 3 grants.

Mr. MICHEL. Do any of these peer reviewers receive research grants or contracts from your Institute?

Dr. ROSENTHAL. Yes, some of the peer reviewers do receive awards from the National Center.

Mr. MICHEL. Do they participate in the review of grant proposals submitted by others from their own institutions?

Dr. ROSENTHAL. No. The National Center has a policy in effect which requires that study section members absent themselves from the meeting room during the discussion of any research grant submitted by the institution to which that member belongs. The executive secretaries oversee this requirement for their respective study sections.

Mr. MICHEL. What is the cost for administering the peer reviews system in your Institute? This should include travel, per diem, consultant fees, secretarial assistance—in other words, the whole gamut of expenditures.

Mr. MICHEL. What is the total cost for administering the peer reviews system for the National Center for calendar year 1975 was $448,676. This cost was for the three study sections and includes all expenditures requested. Individually the HSDG Study Section costs were $217,337; HSR Study Section were $125,548; and HCT Study Section $105,791.

Mr. MICHEL. What kind of a grant monitoring system do you have to insure that the intended research is being pursued and accomplished?

Dr. ROSENTHAL. The National Center presently has a policy where each research group application approved and funded is assigned to a project officer whose function is to monitor the application through its entire project period. In addition the Grants Administration Branch, NCHSR, also monitors all funded research grants. We also subject each grant to an annual review by NCHSR staff and non-Federal reviewers prior to approving continuations.

OPPORTUNITIES FOR MINORITIES AND WOMEN

Mr. ROYBAL. Recently, I received a program description of the Office of Health Resources Opportunity expressing concern for the lack of health manpower opportunities for disadvantaged groups (e.g. minorities, women, the poor). The Office indicates that it conducts "oversight" into all sections of the Health Resources Administration on behalf of the disadvantaged.

What monitoring activities and reviews has the Office conducted regarding participation of minorities and women in health training programs?

Dr. SIMPSON. The Office of Health Resources Opportunity (OHRO) has two main areas of emphasis. It attempts to: (1) develop mechanisms to identify issues and problems and to initiate and support approaches within agency programs to promote equity in access to health resources for the disadvantaged; and (2) develop and implement mechanisms to serve as entry points into agency and other PHS programs for nonprofit public or private health or educational entities which represent the disadvantaged.

To achieve this, OHRO has developed an oversight role through a liaison program and joint planning and evaluation activities. This consists of staff assignments to specific bureaus/centers to identify areas of impact and develop joint proposals. Examples of this effort include: a joint effort with the Bureau of Health Planning and Re-

source Development for consumer education conferences around the country to inform minorities and women of the new planning law, Public Law 93–641, National Health Planning and Resources Development Act of 1974; the expansion of the national ambulatory care survey conducted by the National Center for Health Statistics to increase the sample to 500 black physicians; and the development of a grant program solicitation on the health care of the disadvantaged conducted by National Center for Health Services Research; the development of a survey to describe the characteristics of Spanish-surnamed medical students and physicians; the continuation of a 5-year program sponsored by the Bureau of Health Manpower that would increase the number of Native Americans in health occupations through the support of recruitment, motivation, and retention programs.

In addition, an impact analysis statement to validate the PHS policy on civil rights is to be prepared and submitted with the requests for contracts (RFC) by the project officer. This impact analysis statement was developed and established by OHRO. It should describe what impact the proposed contract activities will have on serving the health needs of the disadvantaged, and how the goals of equal health opportunity will be served.

Mr. ROYBAL. What are its findings with regard to the following areas: health professions; health service scholarship; nursing and dental health; family medicine and primary care training, public health; allied health; physician and dental assistants; and project grants for veterinary medicine, optometry, podiatry, and pharmacy.

Dr. SIMPSON. Our Office administers through the Department of Health, Education, and Welfare Regional Offices a manpower training program entitled "The Special Health Career Opportunity Grant Program" authorized by the Comprehensive Health Manpower Training Act of 1971 Public Law 93–157, section 774(b), it is currently under a continuing resolution. The objective of this program is to support projects which will identify, motivate, recruit, and retain socioeconomic individuals interested in pursuing a health career. The program covers all seven major health professions, public health, nursing, and other health training. Over the past year, the program has spent $23 million and suported 109 programs across the country. In addition to this program which is singularly directed to the disadvantaged population, the Bureau of Health Manpower in Health Resources Administration has some programs which, among other legislative mandates, include a directive for the disadvantaged population.

To enable us to ascertain the impact of the Bureau's programs as well as the special health career oportunity grants program, an evaluation study is being conducted by our Office to determine their degree of impact. We will convey to you the findings of this study as soon as it becomes available. The target date is the end of fiscal year 1977.

As to the National Health Service Corps scholarship program, a selection criterion has been established which gives greater weight to those individuals who identify themselves as belonging to, or having worked with, a minority or ethnic group.

Mr. ROYBAL. What recommendations has the Office made for each of these health fields for improving participation of disadvantaged groups?

Dr. SIMPSON. The Office, through its liaison program, is consistently involved in the development of policies and the reviews of agency grants and contracts with the objective of improving the participation of disadvantaged groups. Specific recommendations are given to individual program areas as the need may be. The Office has also been involved in recommending members to represent the disadvantaged groups to the various agency study sections and councils, thus having input at all levels, from within the agency as well as from the private sector.

Mr. ROYBAL. With regard to its oversight role, the Office carries out "joint planning" and "joint evaluation" activities with other health resources bueraus or sections. Would you please provide a listing of all of the Office's joint activities especially in the health manpower area?

Dr. SIMPSON. As stated before, a joint evaluation study of all health resources administration health manpower training programs which are legislatively mandated by Congress to direct their efforts to the disadvantaged is being sponsored by our Office and the Bureau of Health Manpower.

Our staff, among other activities (1) assists in the development of work plans for their assigned division and/or bureau /centers; (2) develops joint projects; (3) exercises the review and signoff authority; (4) provides technical assistance to applicants eligible under their assigned division and/or bureaus/centers; (5) initiates projects to be conducted by their assigned divisions and/or bureau/center; (6) identifies areas for additional input, review or adaptation; (7) develops agreement statements of work within the agency; (8) disseminates agency information to our target population.

Mr. FLOOD. Mr. Conte.

## HEALTH CARE COSTS

Mr. CONTE. During the past year I believe the National Center for Health Services Research funded some studies on the causes of escalating health care costs. Have any recommendations come out of these studies?

Dr. ROSENTHAL. Several research grants and contracts supported by the National Center for Health Services Research have helped to document those characteristics of our health services industry which have contributed to accelerated inflation. These studies have complemented the research emphasis and findings of other agencies on the inflationary cost incentives embodied in the way we presently pay hospitals through third parties for full historical costs—retrospective reimbursement—and the incentives to use more expensive inpatient rather than ambulatory care facilities as motivated by provider interests and health insurance provisions.

These results, together with ongoing research on factors affecting service intensity and physician payment mechanism and productivity are a subset of other major findings which relate to primary issues of concerns under national health insurance. These findings, which trace out the expected inflationary impact of NHI, have been detailed in my recent testimony before Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, House of Representatives on February 10, 1976. The recommendations which evolve from these findings require even more policy specificity. Nevertheless,

the studies suggest that appropriate emphasis be placed on motivating use of ambulatory care alternatives, on generating incentives for physician pricing and output decisions which are less inflationary, and developing regulatory mechanisms which constrain excessive investment in facility, services, and equipment. I will be happy to submit a list of our findings to date for the record.

[The information follows:]

Research findings concerning escalation of cost of medical services:

1. Increased demand for hospital care has led to the offering of a more technologically sophisticated, and more expensive, hospital product. Hospital wages have also evidenced a dramatic catchup in the recent past. Contributing factors have been existing biases in existing health insurance and the increasing emphasis on defensive medicine (M. Feldstein).

2. Changes in treatment of selected illnesses (for example, appendicitis, maternity care, myocardial infarction) have tended to be cost-raising, that is, costs have risen more than they would have if prices only had changed (Scitovsky).

3. An increase in collection ratios and/or decrease in free care to the elderly by physicians has been associated with medicare supplemental insurance benefits (Sloan).

4. Existing insurance is heavily biased in favor of surgical and in-hospital procedures (Sloan).

5. The quantity of services provided per physician appears to decline as prices increase suggesting that physicians will trade off increased revenue for greater leisure time (M. Feldstein).

6. A comparison of the usual—customary—reasonable (UCR) and traditional fee schedule methods of reimbursing physicians indicates that UCR, used by most private health insurance plans, results in both higher fee levels and faster rates of fee inflation (Sloan).

7. Extended care facilities are complements rather than substitutes for short-term hospitals, and their coverage increases per episode costs (M. Feldstein).

8. While hospital costs increased faster than the Consumer Price Index during 1964–73, inflation did slow appreciably during the period of Cost of Living Council (COLC) regulations. The extent to which this can be ascribed to COLC is not entirely clear, however, since the decline in the hospital inflation rate started in 1970 before COLC was established (Lave).

9. Although certificate-of-need laws have successfully curbed bed expansion, such laws have also prompted hospital to accelerate their costly investment in services, facilities and equipment. Such programs may tend to increase hospital inpatient costs per day while days and admissions per capita have been reduced (Salkever).

Mr. CONTE. Would you explain your proposed expansion in the number of developmental and implementation contracts associated with the Cooperative Health Statistics System?

Mrs. RICE. There is a definite need right now for the data which the Cooperative Health Statistics System can provide. For example professional standards review organizations need data on medical care received in hospitals, and the health planning legislation specifies various data needs for analysis of health status, health resources, et cetera, at the local level.

We feel that the most cost-effective method of providing comparable data for these and other health programs is through the Cooperative Health Statistics System. This System is currently designed to provide comparable and uniform health data at the national, State, and local levels in the areas of vital statistics, health manpower, health facilities, hospital care, long-term care, and ambulatory care.

We now have 39 States involved in one or more of these components of the Cooperative Health Statistics System.

Mr. CONTE. Once health statistics are collected how are they evaluated and disseminated?

Mrs. RICE. All statistical programs of the National Center for Health Statistics employ techniques to evaluate the completeness and reliability of the data obtained. This may involve follow-back studies, reabstracting a sample of records, comparisons with external sources, and other methods. The utility of the various statistical systems are evaluated periodically by means of expert panels, conferences of public health statisticians, a national advisory committee, and in-depth studies.

The dissemination of health statistics is accomplished through many mediums. Identity-free computer tapes containing individual records for a survey are available to qualified researchers. Preliminary findings from surveys are often presented in our monthly periodical, the Monthly Vital Statistics Report, and the final results are published in our Vital and Health Statistics Series. Both of these reports are distributed widely to health professionals and educators are on file in designated libraries across the country. In addition, the Center does prepare many special tabulations and analyses upon request.

Mr. CONTE. Why are loans being phased out? Will the student guaranteed loan program be able to take all of the slack?

Dr. ENDICOTT. Training in the health care field is an excellent personal investment which promises very substantial financial returns. Thus, health professions students should absorb a greater portion of their educational costs. Students needing financial assistance will be able to take advantage of conditional scholarship program requiring the recipient to serve in a shortage area or other public health programs, thus addressing the goal of alleviating the geographic and specialty distribution problems. An improved and expanded guaranteed student loan program administered by the Office of Education for graduate level training is also available to students.

Mr. CONTE. Do you feel that because the nursing student loan program has worked, in that nursing capitation has picked up, it should, therefore, be phased out?

Dr. ENDICOTT. The number of nurses has steadily increased over the years, therefore, the necessity for a special student assistance program is no longer necessary. The nursing student loan and scholarship program will continue to be phased-out during fiscal year 1976 in accordance with present policy. Undergraduate students that are in financial need are encouraged to apply under the expanded Basic Opportunity Grant Program administered by the Office of Education.

Mr. CONTE. Can you give us an idea of the manpower situation in the health field, both geographically and as regards specialties versus primary care?

Dr. ENDICOTT. There are considerable problems of geograhpic and specialty distribution of health manpower in this country. We believe that there are currently areas of the country which are oversupplied as well as undersupplied. Likewise, there are specialties for which there are adequate or excessive supplies of physicians compared to others which are undersupplied. Therefore, to give lump sum rational supply figures for the current situation may not tell the story of our distributional problems. The common assertion that there is a current maldistribution of specialists implies knowledge of a more appropriate distribution. However, at present, there is insufficient information to derive confidently an "optimal" distribution. Hence, present specialty requirements can only be estimated by professional or informed judgment or other proxy measures.

However, even within this context, there are ranges of need dependent on the manpower goals to be set. If the goal were to provide all countries with a minimum of 1 physician for every 2,000 people, another 4,095 physicians would be required now. To reach 1 physician per 1,000 people, 31,000 would be required. On the other hand, if the goal were to assure that each county have as a minimum, one physician in the primary care specialties of family practice, internal medicine, pediatrics, obstetrics, and gynecology for every 2,000 people, then 12,700 physicians are needed.

Our current estimates indicate that it will take about 8,000 to 9,000 physicians to locate in shortages areas now defined under the loan repayment program, designated under section 741(f). Far fewer physicians are required to meet the critical shortage areas under the National Health Service Corps. Thus, there is a range of physicians needed depending on the manpower goals set or the problems to be addressed.

Mr. CONTE. What would your reaction be to a differential capitation grant to non-State supported schools which would try to equalize the gap between the two types of facilities?

Dr. ENDICOTT. The administration's policy is to assist schools training health manpower for the Nation equally. It would not seem appropriate to give different amounts to schools being required to train the same types of health professionals.

For those schools that have exceptional financial problems we have supported a financial distress program. Our 1977 legislative proposal and the budget request would continue such a program.

Mr. CONTE. How does the $337,500 per HSA proposed for fiscal year 1977 compare with last year?

Mr. RUBEL. During fiscal year 1976, all of the HSA's will be conditionally funded at an average level of $168,000. The $337,500 level that you speak of for fiscal year 1977 represents an average level of funding for those agencies which will become fully designated and which will take on the full range of responsibilities.

Mr. CONTE. What type of expertise is required in assisting State and local agencies in adapting and utilizing new planning methods?

Mr. RUBEL. Experience is required in such activities as developing methods for adult education and staff training, examining key monographs or other technical reports, and collecting, compiling, and facilitating access to publications and other literature on health planning.

Mr. FLOOD. Mr. Smith.

NURSING RESEARCH PROJECTS

Mr. SMITH. I would like to know the exact amount allocated within the Health Resources budget for nursing research projects?

Dr. ENDICOTT. No funds are allocated for fiscal year 1977. Administration policy is to phase out these projects.

Mr. SMITH. How many graduate programs in nursing are there?

Dr. ENDICOTT. There are 92 M.A. programs and 12 Ph. D. programs funded under the Nurse Training Act of 1975.

Mr. SMITH. How many schools of nursing offer graduate programs?

Dr. ENDICOTT. There are 92 schools of nursing offering graduate programs.

Mr. SMITH. How many of these are likely to get funded if $3 million is appropriated?

Also do these programs get capitation or any other type of funding?

Dr. ENDICOTT. It is estimated that 15 awards will be made if $3 million is appropriated.

These graduate programs are not eligible for capitation awards but are elgible for funds available from all programs authorized by the Nurse Training Act of 1975.

Mr. FLOOD. Thank you, Doctor.

[The justifications follow:]

# JUSTIFICATION OF THE BUDGET ESTIMATES

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION


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Appropriation Estimate

HEALTH RESOURCES

For carrying out, to the extent not otherwise provided, section *225* 1/ *and* [442], 2/ titles III, VII, VIII, *and* XV [and XVI] 3/ of the Public Health Service Act[,] ; section 1122 of the Social Security Act [,] *and* section 222 of the Social Security Amendments of 1972, [and the District of Columbia Medical and Dental Manpower Act of 1970, as amended, 4/ $360,529,000] *$506,300,000* [of which $7,575,000 shall remain available until expended for carrying out section 305 (b) (3) of the Public Health Service Act, 5/ and $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: 6/ *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: 7/ *Provided further,* That not to exceed $74,260,000 shall be available and expended for medical facilities construction authorized under title XVI of the Public Health Service Act]. 8/

[For an additional amount for "Health resources" for carrying out, to the extent not otherwise provided, title VIII of the Public Health Service Act, $85,000,000.] 9/

[For an additional amount for "Health resources" for carrying out, to the extent not otherwise provided, title VIII of the Public Health Service Act, $6,000,000 for the period July 1, 1976, to September 30, 1976.] 9/

Explanation of Language Changes

1. Language has been added for the National Health Service Scholarship program which was not considered in Congressional action. Passage of authorizing legislation is assumed by fiscal year 1977.

2. Reference to section 442 of the Public Health Service Act has been deleted because the dental health activities previously carried out under this citation will be included in programs to be authorized under section 774.

3. Reference to title XVI of the Act has been deleted because funds are not being requested to carry out construction assistance grant programs in fiscal year 1977.

4. Reference to the District of Columbia Medical and Dental Manpower Act of 1970 has been deleted because funds are not being requested to provide extraordinary assistance to District of Columbia medical and dental schools in fiscal year 1977.

5. Reference to section 305 (b) (3) of the Public Health Service Act has been deleted because funds are not being requested to provide extraordinary assistance to special medical facilities in the District of Columbia in fiscal year 1977.

6. See footnote 2. Further, reference to loan guarantees and interest subsidies under titles VII and VIII of the Act has been deleted because additional funds to maintain current commitments in these programs are not needed in fiscal year 1977.

7. Language has been deleted because funds for this program have been built into the base.

8. The restriction on funds deleted hereby is unnecessary in that funds are not being requested to carry out construction assistance grant programs in fiscal year 1977 (see footnote 2).

9. The language deleted hereby constituted supplemental appropriations in fiscal year 1976.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Amounts Available for Obligation 1/

| | 1976 | 1977 |
|---|---|---|
| Appropriation | $ 570,086,000 | $ 506,300,000 |
| Enacted supplemental appropriation | 85,000,000 | --- |
| Subtotal, appropriation | 655,086,000 | 506,300,000 |
| Comparative transfer to: | | |
| "Office of the Secretary" for establishment of safety management functions, one position in regional office | -23,000 | --- |
| Comparative transfer from: | | |
| "Office of the Assistant Secretary for Health" 14 positions, 13 for decentralization of Parklawn personnel office and one in accordance with Senate Report | --- | --- |
| Subtotal, budget authority | 655,063,000 | 506,300,000 |
| Receipts and reimbursements from: "Social Security Trust Fund" | 42,000 | --- |
| Unobligated balance, start of period | 649,238,000 | 75,938,000 |
| Unobligated balance, end of period | -83,364,000 | -33,368,000 |
| Total, obligations | 1,220,979,000 | 548,870,000 |

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1976 - $658,000 and 16 positions; 1977 - $1,058,000 and 41 positions.

Summary of Changes

| | |
|---|---|
| 1976 Estimated Obligations | $1,220,979,000 |
| 1977 Estimated Obligations | 548,870,000 |
| Net Change | -672,109,000 |

| | 1976 Base Pos. | 1976 Base Amount | Change from Base Pos. | Change from Base Amount |
|---|---|---|---|---|
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Increase to Standard Level User Charge | --- | $2,525,000 | --- | $ +505,000 |
| 2. FTS, postage, etc. | --- | 759,856 | --- | +160,000 |
| 3. Within-grade | --- | 602,000 | --- | +634,000 |
| 4. Increase to Federal Employee Compensation payment | --- | 10,000 | --- | +10,000 |
| 5. Increase in payments to Working Capital fund | --- | 1,004,000 | --- | +338,000 |
| 6. Increase in payments to Service & Supply fund | --- | 73,000 | --- | +114,000 |
| 7. Payments to DFAF system | --- | --- | --- | +48,000 |
| 8. Increase in payments to procurement | --- | 275,000 | --- | +60,000 |
| 9. Annualization of unit costs of reimbursable agreements with other Government Agencies | --- | 4,180,000 | --- | +34,000 |
| 10. Increase in grant and contract continuation costs for health services research, including EMS research which was previously funded in HSA appropriation | --- | 10,900,000 | --- | +1,900,000 |
| 11. Increase cost for NIH service and supply fund | --- | 30,000 | --- | +100,000 |
| Subtotal | | | --- | +3,903,000 |
| B. Program: | | | | |
| (Health Planning & Resources Develop.) | | | | |
| 1. Planning and Resources Development The increase will assist in conditional funding of local agencies, the funding of some full designation agencies, and in funding rate reviews in 1977 | --- | 54,500,000 | --- | +28,000,000 |
| (Health Professions Education) | | | | |
| 2. Health Profession Capitation For national priority awards to initiate geographic and specialty redistribution--225 schools | --- | 101,100,000 | --- | +18,900,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| 3. Health Service Scholarships The increase will support 1,909 additional students who will serve in shortage areas..... | --- | 22,500,000 | --- | +12,500,000 |
| 4. Nurse Financial Distress To stabilize financial condition and help meet accreditation requirements for 10-12 schools..... | --- | --- | --- | +1,000,000 |
| 5. Advanced Nurse Training -- Five additional projects for advanced training in the teaching, administering and supervising fields..... | --- | 2,000,000 | --- | +1,000,000 |
| 6. Nurse Pracitioner -- Adds 16 projects to extend delivery of health services in rural and underserved areas..... | --- | 3,000,000 | --- | +4,000,000 |
| 7. Loan repayments -- Will increase the total nurses working in shortage areas to 1,000..... | --- | 2,500,000 | --- | +500,000 |
| 8. Family Medicine -- Focus on a core curriculum and model family practice and primary care units; provide comprehensive health services-total number of residents supported 2,580..... | --- | 15,000,000 | --- | +24,000,000 |
| 9. Primary Care -- To stress faculty development and improvement and improve training program in general internal medicine, pediatrics and dentistry-total number of projects, 74.. | --- | --- | --- | +18,000,000 |
| 10. Project Grants-VOPP-- To improve curricula and provide clinical training for VOPP schools-90 projects.. | --- | --- | --- | +8,000,000 |
| 11. Project Grants-Public Health To improve health care systems and develop skills of specialize staff-110 projects..... | --- | --- | --- | +8,000,000 |
| 12. Project Grants-Allied Health To support shortage specialties such as primary care, emphasize credentialing-119 projects.... | --- | --- | --- | +8,000,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| 13. Physician/Dental Extenders/ TEAM -- To train physician assistants, dental auxiliaries and dentists which will improve the delivery and efficiency of health service-total projects, 921 | --- | 8,000,000 | --- | +8,000,000 |
| 14. Geographic Maldistribution and AHEC -- To support current AHEC sites a broader range of activities effecting geographic maldistribution-8 more projects and 21 more sites | --- | 12,000,000 | --- | +7,000,000 |
| 15. Foreign Medical Graduates -- To support 14 projects to assist FMG's and U.S. students in foreign schools in providing quality health care | --- | --- | --- | +2,000,000 |
| 16. National Advisory Counsel on Graduate Medical Education -- Will support 3 manpower analytical studies addressing the maldistribution of physicians' problems | --- | --- | --- | +1,000,000 |
| (Health Facilities Construction) 17. Medical Facilities Construction grants -- The increase is the result of project grants bring authorized under the new Health Planning legislation | --- | --- | --- | +8,823,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| (Program Management) | | | | |
| 18. Increase in administration costs to support the Health Services Research intramural research program and expanded project review process..... | --- | 48,484,000 | --- | +302,000 |
| Subtotal..... | | | --- | +159,025,000 |
| Total, increases..... | | | --- | +162,928,000 |
| Decreases: | | | | |
| A. Built-in: | | | | |
| 1. Non-recurring equipment, etc... | --- | 145,000 | --- | -277,000 |
| 2. Less one day of pay..... | --- | --- | --- | -149,000 |
| 3. Decrease in payments to NIH Management Fund..... | --- | 1,448,000 | --- | -746,000 |
| 4. Non-recurring renovation costs. | --- | 206,000 | --- | -206,000 |
| Subtotal..... | | | --- | -1,378,000 |
| B. Program: | | | | |
| (National Health Statistics) | | | | |
| 1. The increase 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..... | --- | 7,023,000 | --- | -1,723,000 |
| (Health Planning and Resources Development) | | | | |
| 2. Planning and Resources development--The decrease reflects the requests of no transition funds in 1977, capital expenditure review activities will be funded from grants to new local and state agencies and a decrease in funds available for planning methods and technical assistance..... | --- | 43,835,000 | --- | -36,335,000 |
| (Health Services Research) | | | | |
| 3. Training grants--phasing out of existing programs..... | --- | 900,000 | --- | -700,000 |
| 4. Intramural research--a decrease in funds available to support new intramural research..... | 38 | 6,442,000 | --- | -524,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| 5. Research grants and contracts Decrease of funds in new and renewal projects..... | --- | 7,700,000 | --- | -2,700,000 |
| (Health Professions Education) | | | | |
| 6. Health Professions Loans-will terminate program in 1977; assistance available through guaranteed loan program, Office of Education or Health Service scholarship program... | --- | 24,000,000 | --- | -24,000,000 |
| 7. Health Professions Scholarships-will terminate program in 1977; authority combined with the conditional Health Service Scholarship program... | --- | 3,500,000 | --- | -3,500,000 |
| 8. Health Professions Loan Repayments-will terminate program in 1977; goals for this program will be incorporated with the Health Service Scholarship program..... | --- | 6,000,000 | --- | -6,000,000 |
| 9. Dental Health Activities-in 1977,will transfer these activities mainly to the Physician/ Dental Extender/TEAM program.. | --- | 8,442,000 | --- | -8,442,000 |
| 10. Nurse Capitation-will terminate program in 1977; federal funds not essential, other financial sources, such as, patient care cost are used..... | --- | 44,000,000 | --- | -44,000,000 |
| 11. Nurse Loans-program being phased out, 6,250 prior year recipients will receive support in 1977, undergraduates have access to basic opportunity grant program in Office of Education..... | --- | 21,000,000 | --- | -16,000,000 |
| 12. Nurse Scholarships-program being phased out, 2,000 prior year recipients will receive support in 1977; undergraduates have access to basic opportunity grant program in Office of Education..... | --- | 6,000,000 | --- | -4,000,000 |
| 13. Nurse Traineeships-will terminate program in 1977; financial assistance available in Office of Education's guaranteed loan program..... | --- | 13,000,000 | --- | -13,000,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| 14. Health Professions Project Grants -- In 1977 these program efforts will be covered under the following programs: Family Medicine, Primary Care and project grants and contracts for VOPP..... | --- | 37,583,000 | --- | -37,583,000 |
| 15. Disadvantaged Assistance -- Will decrease the project support from 70 to 50 for special career opportunity program, no scholarships will be awarded..... | --- | 7,286,000 | --- | -2,286,000 |
| 16. Innovation-Start-up Assistance-will support three programs in 1977; this will complete the phaseout of these schools..... | --- | 3,000,000 | --- | -2,000,000 |
| 17. Financial Distress-will provide support to those schools previously funded; assistance available through capitation grant mechanism..... | --- | 5,000,000 | --- | -2,000,000 |
| 18. Shortage Area Scholarships-will be combined with the Health Service Scholarship program for support in 1977..... | --- | 461,000 | --- | -461,000 |
| 19. Manpower Initiatives -- In 1977 activities formerly conducted by this program are eligible to be carried out under project grants authorities..... | --- | 11,189,000 | --- | -11,189,000 |
| 20. D.C. Medical/Dental Schools-no funds requested in 1977; schools will be able to compete for other Health Manpower funds.... | --- | 9,050,000 | --- | -9,050,000 |
| (Health Facilities Construction) 21. Medical Facilities Construction The increase is the result of no construction funds being requested in 1977..... | --- | 339,110,000 | --- | -307,832,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| 22. Health Teaching Facilities Construction grants-no new funds requested in 1977; future support will be through loan guarantees and interest subsidy payments..... | --- | 299,138,000 | --- | -299,138,000 |
| 23. Health Teaching Facilities Interest Subsidy-no new funds requested in 1977; program will be supported from prior year funds at a reduced level..... | --- | 3,665,000 | --- | -1,196,000 |
| (Program Management) 24. Decreased position strength is concurrent with projected 1977 program reductions in Health Professions Education and Health Services Research..... | 1564 | --- | -57 | --- |
| Subtotal..... | | | -57 | -833,659,000 |
| Total, decreases..... | | | -57 | -835,037,000 |
| Total, net change..... | | | -57 | -672,109,000 |

## Obligations by Activity 1/

| Page Ref. | | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|---|
| 113 | National health statistics | $25,636,000 | $25,636,000 | $24,000,000 | -$1,636,000 |
| | Positions | 478 | 478 | 478 | --- |
| 114 | Health planning and resources development: | | | | |
| | (a) Local planning agencies | 45,000,000 | 35,500,000 | 61,500,000 | +26,000,000 |
| | (b) State agencies | 9,500,000 | 19,000,000 | 19,000,000 | --- |
| | (c) Transition cost | --- | 20,000,000 | --- | -20,000,000 |
| | (d) Planning methods/ technical assistance | 15,835,000 | 15,835,000 | 7,500,000 | -8,335,000 |
| | (Budget authority) | (7,500,000) | (7,500,000) | (7,500,000) | ( ---) |
| | (e) Capital expenditure review | 4,000,000 | 8,000,000 | --- | -8,000,000 |
| | (f) Rate review | --- | --- | 2,000,000 | +2,000,000 |
| | Subtotal, Health planning and resources development | 74,335,000 | 98,335,000 | 90,000,000 | -8,335,000 |
| | (Budget authority) | (66,000,000) | (90,000,000) | (90,000,000) | ( ---) |
| 118 | Health services research. | 26,000,000 | 26,000,000 | 24,000,000 | -2,000,000 |
| | Positions | 18 | 38 | 28 | -10 |
| 124 | Health professions education: | | | | |
| 124 | (a) Health professions: | | | | |
| | (1) Institutional assistance: Capitation grants | 120,000,000 | 101,100,000 | 120,000,000 | +18,900,000 |
| | (2) Student assistance: | | | | |
| | National health service scholarships | 22,500,000 | 22,500,000 | 35,000,000 | +12,500,000 |
| | Loans | 20,000,000 | 24,000,000 | --- | -24,000,000 |
| | Scholarships | 3,500,000 | 3,500,000 | --- | -3,500,000 |
| | Loan repayments | 6,000,000 | 6,000,000 | --- | -6,000,000 |
| | Subtotal | 52,000,000 | 56,000,000 | 35,000,000 | -21,000,000 |
| | (3) Dental health activities | 7,842,000 | 8,442,000 | --- | -8,442,000 |
| | Subtotal, Health professions | 179,842,000 | 165,542,000 | 155,000,000 | -10,542,000 |

Obligations by Activity 1/

| Page Ref. | | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|---|
| 129 | (b) Nursing: | | | | |
| | (1) Institutional assistance: | | | | |
| | Capitation grants..... | --- | 44,000,000 | --- | -44,000,000 |
| | Financial distress..... | --- | --- | 1,000,000 | +1,000,000 |
| | Advanced nurse training..... | 1,000,000 | 2,000,000 | 3,000,000 | +1,000,000 |
| | Nurse practitioner..... | 2,000,000 | 3,000,000 | 7,000,000 | +4,000,000 |
| | Nursing special projects..... | 15,000,000 | 15,000,000 | 15,000,000 | --- |
| | Subtotal..... | 18,000,000 | 64,000,000 | 26,000,000 | -38,000,000 |
| | (2) Student assistance: | | | | |
| | Loans..... | 9,000,000 | 21,000,000 | 5,000,000 | -16,000,000 |
| | Scholarships..... | 4,000,000 | 6,000,000 | 2,000,000 | -4,000,000 |
| | Traineeships..... | --- | 13,000,000 | --- | -13,000,000 |
| | Loan repayments.. | 2,500,000 | 2,500,000 | 3,000,000 | +500,000 |
| | Subtotal..... | 15,500,000 | 42,500,000 | 10,000,000 | -32,500,000 |
| | Subtotal, Nursing.... | 33,500,000 | 106,500,000 | 36,000,000 | -70,500,000 |
| 133 | (c) Special project grants and contracts:.. | | | | |
| | (1) Family medicine residencies training..... | 38,000,000 | 15,000,000 | 39,000,000 | +24,000,000 |
| | (2) Primary care residencies training.. | 15,058,000 | --- | 18,000,000 | +18,000,000 |
| | (3) Health professions project grants. | --- | 37,583,000 | --- | -37,583,000 |
| | (4) Project grants - VOPP..... | 8,000,000 | --- | 8,000,000 | +8,000,000 |
| | (5) Project grants - Public health.. | 8,000,000 | --- | 8,000,000 | +8,000,000 |
| | (6) Project grants - Allied health.. | 8,000,000 | --- | 8,000,000 | +8,000,000 |
| | (7) Physician/Dental extenders/TEAM. | 12,000,000 | 8,000,000 | 16,000,000 | +8,000,000 |
| | (8) Geographic maldistribution and AHEC..... | 19,000,000 | 12,000,000 | 19,000,000 | +7,000,000 |
| | (9) Disadvantaged Assistance..... | 7,000,000 | 7,286,000 | 5,000,000 | -2,286,000 |
| | (10) Foreign medical graduates..... | 2,000,000 | --- | 2,000,000 | +2,000,000 |
| | (11) National advisory committee on graduate medical education..... | 600,000 | --- | 1,000,000 | +1,000,000 |

Obligations by Activity 1/

| Page Ref. | | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|---|
| | (12) Innovation-Start-up assistance.. | 3,000,000 | 3,000,000 | 1,000,000 | -2,000,000 |
| | (13) Financial distress..... | 5,000,000 | 5,000,000 | 3,000,000 | -2,000,000 |
| | (14) Shortage area scholarships..... | 461,000 | 461,000 | --- | -461,000 |
| | (Budget authority) | ( ---) | ( ---) | ( ---) | ( ---) |
| | (15) Manpower Initiatives..... | --- | 11,189,000 | --- | -11,189,000 |
| | Subtotal, Special projects..... | 126,119,000 | 99,519,000 | 128,000,000 | +28,481,000 |
| | (Budget authority) | (125,658,000) | (99,058,000) | (128,000,000) | (+28,942,000) |
| 141 | (d) Medical & Dental Manpower Act of D.C.... | --- | 9,050,000 | --- | -9,050,000 |
| | Subtotal, Health professions education..... | 339,461,000 | 380,611,000 | 319,000,000 | -61,611,000 |
| | (Budget authority) | (339,000,000) | (380,150,000) | (319,000,000) | (-61,150,000) |
| 142 | Health facilities construction: | | | | |
| 142 | (a) Medical facilities: | | | | |
| | (1) Formula grants... | 305,990,000 | 305,990,000 | 31,278,000 | -274,712,000 |
| | (Budget authority)... | ( ---) | (57,923,000) | ( ---) | (-57,923,000) |
| | (2) Project grants... | --- | --- | 8,823,000 | +8,823,000 |
| | (Budget authority)... | ( ---) | (16,337,000) | ( ---) | (-16,337,000) |
| | Subtotal, medical facilities..... | 305,990,000 | 305,990,000 | 40,101,000 | -265,889,000 |
| | (Budget authority)... | ( ---) | ( 74,260,000) | ( ---) | (-74,260,000) |
| 144 | (b) Health teaching facilities: | | | | |
| | (1) Construction grants..... | 299,138,000 | 299,138,000 | --- | -299,138,000 |
| | (Budget authority)... | ( ---) | ( ---) | ( ---) | ( ---) |
| | (2) Interest subsidies..... | 3,665,000 | 3,665,000 | 2,469,000 | -1,196,000 |
| | (Budget authority)... | ( 2,000,000 | ( 3,000,000) | ( ---) | (-3,000,000) |
| | Subtotal, Health teaching facilities..... | 302,803,000 | 302,803,000 | 2,469,000 | -300,334,000 |
| | (Budget authority)... | ( 2,000,000) | ( 3,000,000) | ( ---) | (-3,000,000) |
| | (c) Special medical facilities..... | 22,000,000 | 29,575,000 | --- | -29,575,000 |
| | (Budget authority)... | ( ---) | ( 7,575,000) | ( ---) | (-7,575,000) |
| | (d) D.C. Medical facilities..... | 3,545,000 | 3,545,000 | --- | -3,545,000 |
| | (Budget authority)... | ( ---) | ( ---) | ( ---) | ( ---) |
| | Subtotal, Health facilities construction..... | 634,338,000 | 641,913,000 | 42,570,000 | -599,343,000 |
| | (Budget authority)... | ( 2,000,000) | (84,835,000) | ( ---) | (-84,835,000) |

Obligations by Activity

| Page Ref. | | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|---|
| 146 | Program Management..... | 48,042,000 | 48,484,000 | 49,300,000 | +816,000 |
| | Positions..... | 1,600 | 1,564 | 1,516 | -48 |
| | (Budget authority)..... | (48,000,000) | (48,442,000) | (49,300,000) | (+858,000) |
| | Total Obligations, HRA... | 1,147,812,000 | 1,220,979,000 | 548,870,000 | -672,109,000 |
| | Positions..... | 2,096 | 2,080 | 2,022 | -58 |
| | (Budget authority)..... | (506,636,000) | (655,063,000) | (506,300,000) | (-148,763,000) |

1/ Excludes the following amount for reimbursable activities carried out by this account: 1976 - $658,000 and 16 positions; 1977 - $1,058,000 and 41 positions.

Obligations by Object

| | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Total number of permenent positions..... | 2,080 | 2,022 | -58 |
| Full-time equivalent of all other positions..... | 146 | 176 | +30 |
| Average number of all employees..... | 2,203 | 2,202 | - 1 |
| Personnel compensation: | | | |
| Permanent positions..... | 38,363,000 | 39,642,000 | +1,279,000 |
| Positions other than permanent..... | 2,255,000 | 2,338,000 | +83,000 |
| Other personnel compensation..... | 504,000 | 518,000 | +14,000 |
| Subtotal, personnel compensation... | 41,122,000 | 42,498,000 | +1,376,000 |
| Personnel benefits..... | 4,408,000 | 4,518,000 | +110,000 |
| Benefits for former personnel..... | 25,000 | 25,000 | --- |
| Travel and transportation of persons. | 3,292,000 | 3,353,000 | +61,000 |
| Transportation of things..... | 195,000 | 204,000 | +9,000 |
| Rent, communications and utilities.. | 2,702,000 | 2,885,000 | +183,000 |
| Printing and reproduction..... | 1,231,000 | 1,299,000 | +68,000 |
| Other services..... | 15,537,000 | 14,728,000 | -809,000 |
| Project contracts..... | 86,296,000 | 58,530,000 | -27,766,000 |
| Supplies and materials..... | 673,000 | 740,000 | +67,000 |
| Equipment..... | 706,000 | 640,000 | -66,000 |
| Investments and loans..... | 45,000,000 | 5,000,000 | -40,000,000 |
| Grants, subsidies & contributions... | 1,019,792,000 | 414,450,000 | -605,342,000 |
| Total obligations by object..... | 1,220,979,000 | 548,870,000 | -672,109,000 |

Significant Items in House and Senate
Appropriations Committee Reports

| Item | Action Taken or to be Taken |
|---|---|
| 1975 House Report<br>Detailed Budgets of Program Direction Component<br>1. The Committee directs that here after, the budget should detail the direct operation budgets of the nursing, dental and other programs of the Health Resources Administration, the level of detail shall be such that salaries, positions, travel, and consultation will be clearly identified for each component rather than lumping the division budgets into one overall program direction component (page 57 of the House Report). | See page 147 of this justification |
| 1975 Senate Report<br>Detailed Budgets and Statement of Plans for Dental Health and Nursing Activities<br>2. The Committee notes with extreme concern the Administration's low budget requests for the Division of Dentistry and Nursing. This has been accompanied by a corresponding decrease in positions and, of course, program activities over the past two years. These actions, accomplished by administrative fiat, fly in the face of repeated admonitions from this committee and its counterpart in the House directing the Department to maintain an organizational focus for these activities. It is a particular source of dismay to the Committee that the Division of Dentistry's strong program devoted to the application of dental disease prevention measures has been phased down until it is essentially nonexistent. Such actions run counter to the Department's announced intentions with respect to emphasis on prevention of disease and are contrary to the public interest. The Committee directs, therefore, that the Department submit a detailed budget and statement of those programs being undertaken by the National Institute of Dental Research. | 2. As in the past, the Health Resources Agency plans to continue separate organizational focuses for dental and nursing activities in the Bureau of Health Manpower. Increased demands on limited national fiscal resources coupled with substantive administrative changes in the organization of the Public Health service, including decentralization of Health Manpower programs, in some instances has resulted in position and budget reallocations. A budget table which has been furnished to the Congress will show that a considerable amount of Bureau of Health Manpower resources are directed into Dental and Nursing programs. These programs include Capitation, Special Projects, Financial Distress, Expanded Function Auxiliaries, Student Assistance and other intramural and Extramural activities.<br><br>The Administration does recognize that deficiencies exist in national dental and nurse training resources. In response to these concerns program funds have been targeted to special areas of need. |

Significant Items in House and Senate
Appropriation Committee Reports

| Item | Action taken or to be taken |
|---|---|
| 1975 Senate Report | |
| Health Manpower | |
| (2 continued) | (2 continued) |
| This report should include a comparative summary showing the activities that have been discontinued and transfers that have taken place since fiscal years 1973 and 1974 (pages 74 and 75 of the report). | In addition, new health manpower legislation addressing issues in dentistry, medicine, and the other health professions has recently been submitted to the Congress for their consideration.<br><br>Since the reorganization of the Public Health Service in 1973, transfers of Dental programs include the HEADSTART activities to the Bureau of Community Health in the Health Services Administration (July 1, 1975) and the reassignment of prevention activities to the Center for Disease Control in Atlanta (June 1975). There were no transfers of nursing programs. |

Authorizing Legislation

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| Health Resources (Public Health Service Act) | | |
| 1. Health Services Research Section 308(1)(1)..... | 80,000,000 1/ | 24,000,000 |
| 2. Health Statistics Section 308(1)(2)..... | 30,000,000 | 24,000,000 |
| 3. Health Planning and Resources Development: | | |
| (a) Local planning agencies (Sec. 1516)..... | 125,000,000 | 61,500,000 |
| (b) State agencies (Sec. 1525)..... | 35,000,000 | 19,000,000 |
| (c) Planning methods development (Sec. 1534)..... | 10,000,000 | 7,500,000 |
| (d) Resources development fund (Sec. 1640)..... | 120,000,000 | --- |
| (e) Rate review (Sec. 1526)..... | 6,000,000 | 2,000,000 |
| 4. Health Manpower: | | |
| (a) Health Professions Institutional Assistance: Capitation grants (Sec. 770)..... | 2/ | 120,000,000 |
| (b) Health Professions Student Assistance: | | |
| (1) Loans (Sec. 742)..... | Such sums as necessary | --- |
| (2) Scholarships (Sec. 780)..... | Such sums as necessary | --- |
| (3) Loan repayments (Sec. 741)... | 2/ | --- |
| (4) Health service scholarships (Sec. 225)..... | 3/ | 35,000,000 |
| (c) Nursing Institutional Assistance: | | |
| (1) Capitation (Sec. 810)..... | 55,000,000 | --- |
| (2) Financial distress (Sec. 815)..... | 5,000,000 | 1,000,000 |
| (3) Advanced nurse training (Sec. 821)..... | 20,000,000 | 3,000,000 |
| (4) Nurse practitioners (Sec. 822)..... | 20,000,000 | 7,000,000 |
| (5) Nursing special projects (Sec. 820)..... | 15,000,000 | 15,000,000 |

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| (d) Nursing Student Assistance: | | |
| (1) Loans (Sec. 837)..... | 30,000,000 | 5,000,000 |
| (2) Scholarships (Sec. 845)..... | Formula | 2,000,000 |
| (3) Traineeships (Sec. 830)..... | 20,000,000 | --- |
| (4) Loan repayments (Sec. 836)... | Such sums as necessary | 3,000,000 |
| (e) Special Projects: | | |
| (1) Family medical residencies and training (Sec. 767)..... | 2/ | 39,000,000 |
| (2) Primary care residencies and training ..... | 4/ | 18,000,000 |
| (3) Project grants - VOPP (Sec. 772)..... | 2/ | 8,000,000 |
| (4) Project grants - Public Health (Sec. 313)..... | 2/ | 8,000,000 |
| (5) Project grants - Allied Health (Sec. 792)..... | 2/ | 8,000,000 |
| (6) Physician/Dental extenders/TEAM (Sec. 774)..... | 2/ | 16,000,000 |
| (7) Geographic Maldistribution and AHEC (Sec. 774)..... 5/ | 2/ | 19,000,000 |
| (8) Disadvantaged assistance (Sec. 774)..... 5/ | 2/ | 5,000,000 |
| (9) Foreign medical graduates.... | 4/ | 2,000,000 |
| (10) National Committee on Graduate Medical Education... | 4/ | 1,000,000 |
| (11) Innovation-Start-up assistance (Sec. 771)..... | 2/ | 1,000,000 |
| (12) Financial Distress (Sec. 773) | 2/ | 3,000,000 |
| (13) Shortage area scholarships (Sec. 789)..... | Such sums as necessary | --- |
| (f) Medical and Dental Manpower Act of D.C..... (D.C. Medical and Dental Act of 1970, extension) | 6/ | --- |
| (g) Health facilities Construction (Sec. 1613)..... | 135,000,000 | --- |
| (h) Health Teaching Facilities Construction: | | |
| (1) Health professions (Sec. 720) | 2/ | --- |
| (2) Nursing (Sec. 801)..... | 20,000,000 | --- |

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| (i) Health Teaching Facilities Interest Subsidies: | | |
| (1) Health professions (Sec. 729). | 2/ | --- |
| (2) Nursing (Sec. 805)..... | 1,000,000 | --- |
| 5. Program Management..... | Inherently Authorized | 49,300,000 |
| Total..... | | 506,300,000 |

1/ Section 310(b), PHS Act, provides that the authorization provided by Section 308(i) of PHS Act is extended for fiscal year ending September 30, 1977, in the amounts authorized for the preceding fiscal year unless before June 30, 1976, Congress passed legislation repealing this subsection.

2/ Authorization expired June 30, 1974. Extension legislation is proposed.

3/ Authorization expired June 30, 1975. Extension legislation is proposed.

4/ No previous authorization. Legislation proposed.

5/ Cited authority (Section 774) only for AHEC and Special Health Career Opportunity grants. New legislation proposed for Geographic Maldistribution and Scholarships portion of Disadvantaged Assistance.

6/ Authorization expired June 30, 1976. Extension legislation is proposed.

Health Resources Administration

| Year | Budget Estimate To Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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 | 213,757,000 | 819,606,000 | 817,281,000 | 825,826,000 |
| 1976 | 343,329,000 | 660,367,000 | 672,187,000 | 307,700,000 |
| 1977 | 506,300,000 | | | |

Justification

Health Resources

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Personnel compensation and benefits | $45,513,000 | $45,513,000 | $47,041,000 | +$1,528,000 |
| Other expenses | 461,123,000 | 609,550,000 | 459,259,000 | -150,291,000 |
| Total | 506,636,000 | 655,063,000 | 506,300,000 | -148,763,000 |
| Positions | 2,096 | 2,080 | 2,022 | -58 |

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 $506,300,000 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 $24,000,000 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). These agencies are designed

to improve the quality and delivery of health services throughout the Nation while at the same time containing the cost of providing health services and preventing unnecessary duplication of health resources. It is proposed to have approximately half of the potential 211 health systems agencies be given full designation in 1977, enabling them to assume responsibility for all of the major functions included in the authorizing legislation. The remaining agencies would continue to be funded for a second year of conditional designation.

In addition, 56 State Agencies will be funded, gradually assuming the range of functions of integrating the local plans into a State health plan, implementing certificate of need laws, and providing staff support to the statewide Health Coordinating Council.

Funds are also requested for the development of more effective planning methods, and continued progress toward establishing ten planning centers across the country, which will provide training and consultation to the staff and council representatives of the State and local planning agencies. Rate review demonstrations will be established in up to six States. A funding level of $90,000,000 is requested for this range of activities under the health planning and resources development program.

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). The Center 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, 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 $24,000,000.

The 1977 request of $319,000,000 for health manpower is based upon the Administration's proposed legislation, the "Health Professions Education Amendments of 1975." The proposal would shift the emphasis of Federal support from merely increasing enrollments to addressing national specialty and geographic maldistribution problems. The budget provides for continuing capitation grants - institutional support awarded on a formula basis - to those schools of medicine, osteopathy, and dentistry agreeing to undertake special efforts designed to address geographic and specialty distribution. Capitation for other health professions schools would be phased out because there are not substantial geographic and specialty distribution problems for graduates of these schools.

The Health Service Scholarship Program is designed to replace existing scholarship efforts. Scholarships would be provided to medical, osteopathic, and dental students in exchange for service in a health manpower shortage area, or for service in the Public Health Service or other Federal health service.

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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 opportunities for physician assistants, dental auxiliaries, and nursing practitioners; the provision of graduate training in important public health related fields; improvement of allied health professions training; the provision of financial assistance to individuals from disadvantaged backgrounds to enable them to enter health professions careers; expanded efforts to improve the quality of foreign medical graduates; and training activities designed to help solve the serious problems of geographic maldistribution of health professionals.

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 disadvantaged. OHRO 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. Agency contract funds will be spent on OHRO activities in addition to those activities specifically legislated or identified by the Bureaus in 1977.

National Health Statistics

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Personnel compensation and benefits..... | $9,420,000 | $9,420,000 | $9,800,000 | +$380,000 |
| Other expenses..... | 16,216,000 | 16,216,000 | 14,200,000 | -2,016,000 |
| Total..... | 25,636,000 | 25,636,000 | 24,000,000 | -1,636,000 |
| Positions.... | 478 | 478 | 478 | --- |

The National Center for Health Statistics develops and maintains reliable, general purpose, health statistical data collection systems; performs studies to improve health survey methods; provides technical advice on the application of statistical methods; and exerts leadership in the development of a national cooperative health statistics system with State and local agencies, directed toward producing comparable and uniform health data for planning and evaluation of health care programs at the Federal, State, and local levels. Data provided through the CHSS system will be those which accurately and adequately reflect (1) the health of the people, (2) the available health resources--facilities, manpower, and services, (3) the use and cost of health services, (4) the character and quality of the environment as it relates to health, (5) the basic demographic characteristics of the population, including patterns of family growth, births, deaths, marriages, and divorces, and (6) the knowledge, practices, and attitudes toward health and health care. The system will thus produce the data needed on a continuing, periodic, or ad hoc basis for the broad assessment of the health status of the population and the planning, management, and evaluation of the delivery of health services.

Impact of 1977 Budget:

The objectives of the data strategy to be supported by the proposed budget are to continue to provide reliable National descriptive baseline health statistics; to identify and measure problems and trends in health status and to identify efficiencies and deficiencies in the distribution supply, utilization, and costs of health care resources and services for planning, management, and evaluation purposes; and to continue the implemented portion of the cooperative system of data collection with States and local areas for producing comparable uniform data at the National, State, and local levels. Specifically, activity in the Cooperative Health Statistics System will maintain only the projects that were in the implementation stage in 1976 as follows: vital statistics, 23 states; health facilities data, 5 States; and health manpower, 9 States.

This budget request includes 25 reimbursable positions to enable the Center to provide assistance to other government agencies with respect to health data collection systems. These positions in addition to the regular personnel ceiling are similar to the operations of the Bureau of the Census and the Bureau of Labor Statistics. The positions would be used by NCHS to provide technical assistance, add items to its ongoing surveys, conduct followback surveys based on previous NCHS data collection, conduct special surveys, or provide special analyses of available data for agencies in DHEW or other Federal agencies.

Health Planning and Resources Development

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Local planning agencies | $45,000,000 | $35,500,000 | $61,500,000 | +$26,000,000 |
| State agencies | 9,500,000 | 19,000,000 | 19,000,000 | --- |
| Transition costs | --- | 20,000,000 | --- | -20,000,000 |
| Planning methods/technical assistance | 7,500,000 | 7,500,000 | 7,500,000 | --- |
| Capital expenditures review | 4,000,000 | 8,000,000 | --- | -8,000,000 |
| Rate review | --- | --- | 2,000,000 | +2,000,000 |
| Total | 66,000,000 | 90,000,000 | 90,000,000 | --- |

The health system of our Nation embodies deficiencies and inequities affecting vast numbers of our population. Large segments of our population are not receiving adequate health care, particularly in rural areas and in low income sections of our larger cities. Inner city areas and remote rural sections alike are served by too few doctors; primary care is often available only in crowded emergency rooms or by driving long distances to see a physician. Yet in the affluent areas of our cities we may be building too many hospitals, proliferating underutilization which is a wasteful expense and one that is passed on to the patient, and creating problems in staff recruitment and education. These are some of the reasons why our Nation's health costs have risen from $75.6 billion in 1971 to in excess of $113 billion annually in 1975, and health expenditures are still rising.

Appropriate planning and coordination in the development of health resources is necessary in order to improve the financial access to health care. Without rational and efficient planning, the costly problems of duplication and underutilization of health care facilities and maldistribution of health manpower would make it impossible (or very expensive) to improve financial access to health care.

Some tentative steps have already been taken to bring order and coordination to the interacting elements comprising our health system. The Comprehensive Health Planning legislation enacted in 1966 embodied some guiding principles that are still valid today. However, it contained a lack of focus and clear delineation of mission, as well as an absence of a truly effective mechanism for translating knowledge into planning and planning into action. Based on experience with that system - on its successes and in recognition of its deficiencies - a modified and strengthened authority for health planning has been enacted into law.

The Health Planning and Resources Development Act of 1974 calls for the creation of a nationwide network of Health Systems Agencies and State Health Planning and Development Agencies responsible for health planning and resources development. The Health Planning and Resources Development program is designed to improve the quality and delivery of health services throughout the Nation, while at the same time containing the cost of providing health services and preventing unnecessary duplication of health resources.

Impact of 1977

A budget level of $90,000,000 is requested for implementation of the Health Planning and Resources Development program. During FY 1976, 211 health systems agencies (HSAs) and 56 State agencies are expected to be conditionally designated and funded for their first year of operations. The amount requested for 1977 would allow for full designation of approximately 111 HSAs, enabling them to assume responsibility for all of the major functions included in the authorizing legislation. The 100 remaining agencies would be continued for a second and final year of funding under conditional designation. Specifically, the 1977 request would impact on the planning and resources development activities as follows:

Health Systems Agencies (HSAs): The budget request would provide $61,500,000 for this activity. The purpose of this activity is to improve the health of the residents of the area; increase the accessibility, acceptability, continuity, and quality of health services in the area; restrain increases in the cost of providing health services; and prevent unnecessary duplication of health resources. Among the functions required of the HSAs are the development of a Health Systems Plan (statement of long-term goals), and an Annual Implementation Plan which describes the objectives to be used in achieving the goals.

Of the 211 HSAs conditionally designated and funded in 1976, approximately 111 will receive full designation. This request would allow for an average level of funding of approximately $385,000 for each of the fully designated HSAs and would support approximately 15.5 staff for each local agency. The remaining 100 agencies would continue to be funded for a second and final year of conditional designation at an average level of $187,000.

State Health Planning and Development Agencies: The budget request would provide $19,000,000 for this activity. The functions of the State agency include organizational development, establishment of procedures and criteria for review of health systems changes, integration of the health plans of the HSAs into a State health plan, administering the facilities construction program, implementing the certificate-of-need laws, and providing staff support to the Statewide Health Coordinating Council. The State agency is also required to make findings as to the need for all new institutional services proposed to be offered in the State, and the appropriateness of existing services.

Most of the 56 State agencies conditionally designated and funded in FY 1976 will be continued for a second and final year of funding under conditional designation, with a few being moved to full designation depending on their ability to assume the full range of functions provided in the legislation. This request would allow for an average level of approximately $337,500 per State agency. Federal funding for this activity may not exceed 75 percent of the total of each agency's operating costs. Given State matching, the average total agency budget would be $450,000, which would provide for a total agency staff of approximately 18.

Planning Methods and Technical Assistance: The budget request would provide $7,500,000 for this activity. The purpose of this activity is to develop effective planning methods and to provide technical assistance to State and local agencies in evaluating, adapting, and utilizing new planning methods. These funds would be used to focus on alternative approaches to resource allocations and to refine existing methods of implementing plans and developing health resources. In addition, where appropriate, technical assistance will be provided to grant applicants. The National Health Planning Information Center established during FY 1976 to facilitate the exchange of information concerning health services, health resources and health planning and resources development practice and methodology would be continued during FY 1977.

The Law requires that plans of health systems agencies and State Health Planning and Development agencies analyze (1) the health status of the populations they serve, and (2) the health systems which serve that population. These agencies are then to propose goals and objectives which will provide for a change in health systems and environment to improve the health status of their population. In FY 1977, activities supported through this program will include:

- Developing methods which satisfy the mandated need for agencies to determine continuity and acceptability of care in their community and the impact that these have on cost.

- Developing methods to aid the agencies in making determinations on the acceptable levels of resources which will be required for the delivery of the care.

- Aid to agencies in their determination of better methods to measure health status with a focus on measures which are cost effective and easily capable of being used.

Methods of determining the resources requirements as they relate to varying levels of accessible, continuous and acceptable quality of care and the relationship of these requirements to the cost of care at the community level are all aspects which we now know little about. Such determinations will not only be beneficial to the agencies in their planning processes but will also help to serve as criteria and standards in their review of services undertaken in the regulatory activities.

These methods will require data generation and analysis in order that the agencies may be better able to decide on the appropriate ways to improve the health status of their populations in relation to the health systems provided and the environment.

Intensive training and consultation programs will be provided through the 10 health planning centers established in FY 1976 in order to train and educate approximately 10,000 staff and board members in how to perform these functions. This information will also be disseminated through the National Health Planning Information Center.

Rate Review: The budget request would provide $2,000,000 for this activity. The purpose of this activity is to fund projects to demonstrate the effectiveness of regulating rates for the provision of health care. The program is optional for States willing to undertake efforts aimed at the regulation of rate setting. In addition to containing costs, these demonstration efforts are designated to improve overall cost consciousness among hospital and medical staff by promoting improved budgeting practices, detailed justification of capital expenditure requests, and the introduction of systems to monitor costs against budgets.

This activity will be coordinated with the Social Security Administration and will be carried out in conjunction with Section 222 of the Social Security Amendments of 1972, which has to do with testing prospective reimbursements.

The budget request would provide for six rate review demonstration projects, to be jointly funded by this activity and the Social Security Administration.

## Health Services Research

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Research grants and contracts..... | $18,600,000 | $18,600,000 | $17,800,000 | -$800,000 |
| Intramural research... | 6,500,000 | 6,500,000 | 6,000,000 | -500,000 |
| Research training..... | 900,000 | 900,000 | 200,000 | -700,000 |
| Total..... | 26,000,000 | 26,000,000 | 24,000,000 | -2,000,000 |

The National Center for Health Services Research was established in accordance with the provision of Public Law 93-353, the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. Part of this law amends section 304, 305, and 308 of the Public Health Service Act and provides the authorities for the four generic activities which together constitute the program of the National Center: 1) Research, demonstration, and evaluation projects; 2) Extramural Health Services Research Centers; 3) Research training; and 4) Information dissemination.

The 1977 budget request of $24,000,000 is a decrease of $2,000,000 from the 1976 level of support. The budget request will permit the National Center to support continuation projects and several new starts in the high priority areas of Health Manpower, and Long-Term Care.

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| (1) Research Grants and Contracts: | No. | Amount | No. | Amount | No. | Amount |
| Research, demonstration and evaluation grants: | | | | | | |
| Non-competing continuations..... | 53 | $8,900,000 | 75 | $11,300,000 | +22 | +$2,400,000 |
| Renewals..... | 11 | 2,000,000 | 7 | 1,500,000 | -4 | -500,000 |
| New grants..... | 40 | 4,700,000 | 20 | 2,500,000 | -20 | -2,200,000 |
| Supplementals..... | (15) | 500,000 | (15) | 500,000 | (--) | --- |
| Subtotal..... | 104 | 16,100,000 | 102 | 15,800,000 | -2 | -300,000 |
| Contracts: | | | | | | |
| Continuations..... | 15 | 1,500,000 | 10 | 1,000,000 | -5 | -500,000 |
| New contracts..... | 10 | 1,000,000 | 10 | 1,000,000 | -- | --- |
| Subtotal..... | 25 | 2,500,000 | 20 | 2,000,000 | -5 | -500,000 |
| TOTAL..... | 129 | 18,600,000 | 122 | 17,800,000 | -7 | -800,000 |

| | 1976 Appropriation Pos. | Amount | 1977 Estimate Pos. | Amount | Increase or Decrease Pos. | Amount |
|---|---|---|---|---|---|---|
| 2) Intramural Research: | | | | | | |
| Personnel compensation and benefits..... | 38 | $798,000 | 28 | $1,084,000 | -10 | +$286,000 |
| Other expenses..... | -- | 602,000 | -- | 800,000 | -- | +198,000 |
| Contracts/Interagency agreements..... | -- | 5,100,000 | -- | 4,116,000 | -- | -984,000 |
| TOTAL..... | 38 | 6,500,000 | 28 | 6,000,000 | -10 | -500,000 |

Distribution of Research Projects by Program Areas

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| A. Health Services Research: | | | |
| Inflation and Productivity..... | $2,500,000 | $1,800,000 | -$700,000 |
| Health Insurance..... | 3,200,000 | 2,600,000 | -600,000 |
| Health Manpower..... | 3,000,000 | 3,000,000 | --- |
| Quality of Care..... | 5,000,000 | 3,000,000 | -2,000,000 |
| Planning and Regulation..... | 1,700,000 | 1,300,000 | -400,000 |
| Health Care and the Disadvantaged.. | 2,100,000 | 1,700,000 | -400,000 |
| Long-Term Care..... | 1,500,000 | 2,016,000 | +516,000 |
| Emergency Medical Services..... | --- | 1,800,000 | +1,800,000 |
| Subtotal.... | 19,000,000 | 17,216,000 | - 1,784,000 |
| B. Health Services Research Centers Program..... | 4,200,000 | 4,200,000 | --- |
| C. Information Dissemination Program..... | 500,000 | 500,000 | --- |
| Total..... | 23,700,000 | 21,916,000 | -1,784,000 |

A. Health Services Research

The primary activity of the National Center is to support and conduct a program of research which will contribute to improvements in the way health services are produced, organized, distributed and financed. The majority of the resources used to support this research is expended through extramural grants and contracts. However, section 308, as amended, now requires that at least 25% of the annual appropriation for the National Center be used to support research undertaken by the staff. With the additional positions provided by the Congress in 1976 and through the implementation of a Fellowship Program and the temporary employment of senior scholars under the Intergovernmental Personnel Act, it is anticipated that the National Center will use a substantial portion of these research funds in 1977. The intramural research program encompasses projects conducted by staff of the National Center, as well as those undertaken jointly with members of other units of the Department.

Of the utmost importance is the responsibility the National Center bears for designing and articulating a research agenda. Because it is the largest single source of resources for the conduct or support of health services research, the National Center's research agenda is likely to generate critical inputs to future health care policy deliberations.

Recognizing the importance of its substantive decisions, the National Center now establishes its research priorities through intensive interaction with those who have particular need for information - decision makers in the executive and legislative branches of the Federal government, various representatives of state and local government, providers, and the research community. These priorities are determined by what appear to be the most pressing and current issues in public policy. Eight major issue areas have emerged from this process: 1) Inflation and Productivity (the cost-containment issue); 2) Health Insurance; 3) Health Manpower; 4) Quality of services; 5) Planning and Regulation; 6) Health Care and the Disadvantaged; 7) Long-Term Care; and 8) Ambulatory Care - Emergency Medical Services.

1) Inflation and Productivity - A critical problem for the public and private sectors over the past two decades has been the rapid escalation in the cost of medical services. In the past year the National Center has funded a number of studies to investigate this problem. Research is underway to determine the factors responsible for the increase in hospital costs, to explore the effects of alternative ways of delivering services on expenditures, and to ascertain the critical determinants of wages and prices in this industry. In 1977 the National Center will give major attention to two critical unresolved problems; 1) the development of a realistic price index for this industry to permit better estimates of inflation and productivity changes, and 2) the analysis of the pattern of expenditures.

2) Health Insurance - The problem of how to finance medical services is an issue that is second in importance only to the issue of the costs of these services. Research supported by the National Center over the past several years is reflected in the informed debates that are now taking place around this issue. Given its present resources and the most common demands for information, the National Center has emphasized over the past year approaches to and potential consequences of providing a catastrophic insurance benefit on a national basis. In 1977 the National Center will continue to explore this issue.

3) Health Manpower - Central to the debate over health manpower legislation are questions related to the supply of primary and specialty services and their geographic distribution. In the past the research program has primarily concentrated on ways of dealing with these issues without expanding the supply of physicians. Increased substitution of nurses and medical corpsmen, and technology in the production of selected health services can be traced directly to the research activities of the National Center. Research on physician substitution and productivity will continue. However, the National Center also intends in 1977 to examine more closely the non-physician labor market, where the cost and availability of health services may be significantly affected by mobility patterns, employment practices and the growth of collective bargaining.

4) Quality of Care - Defining the outcome of the medical care process and establishing the nature of the relationships between specific processes and subsequent outcomes are critical prerequisites to comparisons of the costs of providing care in different settings, to evaluations of technological innovations, and to assessments of changes in the performance of the sector. The research program will continue to assign a high priority to these aspects of the quality issue. In addition, efforts will be continued in 1977 to improve the efficiency and effectiveness of health services through the further development of such tools as computer assisted diagnosis, problem oriented records, and treatment protocols.

5) Planning and Regulation - The passage of Public Law 93-641 provides an administrative vehicle for controlling investment in the health care sector. However, the mechanisms for estimating the nature of demand for services, for determining the consequences of particular types of investment, and for assessing the consequences of various types of regulation remain to be developed. If the present attempt to centralize investment decisions and control costs and distribution of services is to succeed, the technology of planning must be advanced substantially. Given sufficient means the National Center intends to explore quantitative modeling techniques, analyses of the social and political aspects of planning and the data demands of this activity.

6) Health Care and the Disadvantaged - The problem of access to medical care and the factors which determine the quantity and quality of services consumed remains a critical issue in public policy. The National Center is currently supporting an intensive effort to define and quantify the access problem. However, the broader question of the utilization and impact of health care on various disadvantaged groups has yet to be adequately addressed. The National Center has issued a grant solicitation to encourage work in this area to be supported in 1976 and continued in 1977.

7) Long-Term Care - As the elderly population grows and as people of all ages with chronic health conditions survive longer, Congress is under increasing pressure to extend long-term care assistance programs. However, there is no consensus as to a course of action which would make adequate long-term care services available to those who need them. This is due in part to a lack of information and analysis to guide policy formulation. The National Center will support empirical studies as well as methodologic and theoretical research relevant to such basic policy concerns as the dimensions of demand for long-term

care, the supply and access effects of existing insurance and regulatory policies, and the cost and distributive implications of alternative assistance strategies. A program solicitation inviting research proposals to deal with Long-term care will be published in mid - 1976; approved grant proposals will be funded in 1977.

8) Emergency Medical Services - In recent years the providers of emergency medical services have become an important source of primary care. The expansion of the system to provide emergency services has exposed problems related to the unpredictable nature of the case load and the random occurance of events. As one aspect of research on ambulatory care, the National Center will support research on the effectiveness of emergency services, as well as studies which explore alternative means of delivering these services and evaluate new techniques and procedures for producing emergency services. A program solicitation inviting research proposals dealing with emergency medical services was published in 1976, and approved proposals will be funded in 1976 to carry through 1977.

In 1975-1976, the emergency medical services research program was funded from the Health Services Administration appropriation and administered by the National Center. The Administration is not proposing extension of the legislative authorization (Section 1205, PHS Act) for this program, and thus the National Center is requesting funds to meet estimated continuation commitments.

B. Extramural Health Services Research Centers Program

A grant program to support the development and operation of a small number of extramural Health Services Research Centers was initiated in 1968. This program was given a statutory base with the enactment of P.L. 93-353.

The new Health Services Research Centers program requires that Centers be established within academic or non-profit research institutions, have a multidisciplinary staff, have working relationships for research purposes with providers, and address questions of local, regional, or national importance. The National Center requested applications for grants for Research Centers and will make several awards in 1976.

It is the position of the National Center for Health Services Research that the legislative requirement that six centers be funded each year is a base, not a ceiling. The National Center's long-run objective is to have at least one operational Research Center in each DHEW Region. In addition to dealing with the geographic distribution of Research Centers, the National Center would also award several planing grants in 1977 to encourage the development of research centers in institutions that have not been previously involved in health services research.

C. Information Dissemination Program

In order to increase the effectivness and utility of its research programs, Public Law 93-353 requires the National Center for Health Services Research to coordinate the health services research being undertaken or supported through units of the Department, and to give increased emphasis to the problem of making the results of such research known to those likely to employ them in improving the efficiency and general performance of the health care system. The National Center intends to pursue the need for better coordination and dissemination of health services research in an aggressive manner. The central feature of the coordination effort will be the preparation of a quarterly report identifying and summarizing health services research supported by the Department and other sources.

With respect to the dissemination of research findings, the National Center intends to issue a series of monographs in 1977. Among these monographs will be research reviews, focused on issues of immediate importance. The National Center will also explore the feasibility of publishing a journal as a way to reduce the time interval between the generations of research findings and their appearance in print.

D. Health Services Research Training Programs

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | No. | Amount | No. | Amount | No. | Amount |
| Existing projects-termination cost..... | 25 | $900,000 | 15 | $200,000 | -10 | -$700,000 |

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 1977, 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 1977 level of funding is $200,000 and reflects a decrease of $700,000 below the 1976 level.

Health Professions Education

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Health professions.. | $172,000,000 | $157,100,000 | $155,000,000 | -$2,100,000 |
| Dental (under Special projects in 1977)..... | 7,842,000 | 8,442,000 | (5,500,000) | -8,442,000 |
| Nursing..... | 33,500,000 | 106,500,000 | 36,000,000 | -70,500,000 |
| Special projects.... | 125,658,000 | 99,058,000 | 128,000,000 | +28,942,000 |
| D.C. medical/dental schools..... | --- | 9,050,000 | --- | -9,050,000 |
| Total..... | 339,000,000 | 380,150,000 | 319,000,000 | -61,150,000 |

The 1977 Budget for Health Manpower activities is presented with the knowledge that legislative authorization has been enacted only for the Nursing activity. Authorizing legislation for the remaining activities, which expired June 30, 1974, is now in the process of being renewed by Congress. The funds requested in 1977 are based upon the Administration's proposed legislation in 1975. This legislation is aimed at achieving the following objectives: encouraging the maintenance of existing enrollment levels; targeting support to solve distributional problems, both specialty and geographic; and increasing productivity through more efficient use of personnel.

Health Professions

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Institutional Assistance..... | $101,100,000 | $120,000,000 | +$18,900,000 |
| Student Assistance..... | 56,000,000 | 35,000,000 | -$21,000,000 |
| Total ..... | 157,100,000 | 155,000,000 | -2,100,000 |

Support is provided for basic financial assistance to health professions education institutions and students and to improve geographic and specialty disbribution of health professions.

Institutional Assistance

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Capitation..... | $101,100,000 | $120,000,000 | +$18,900,000 |

Capitation

The 1977 request of $120,000,000 for these grants reflects an increase of $18,900,000 over the 1976 level. These grants are awarded on a formula basis, as contained in legislation, to schools of medicine, dentistry, osteopathy, veterinary medicine, optometry and podiatry. The budget request of $120,000,000 is based on the administration's policy of supporting medical, osteopathic, and dental schools who are willing to participate in a geographic and specialty redistribution initiative. Capitation to veterinary medicine, optometry and podiatry schools and all other MOD schools which do not participate in a geographic and specialty redistribution initiative will be phased out. Capitation for schools of pharmacy would be eliminated because their training programs are predominately undergraduate in nature and because specialty and geographic distribution of their graduates has not been shown to be a problem. The 1977 request will support an estimated 225 schools.

FY 76

| Type of School | Enrollment | X | Formula Amt Per Student* | = | Total |
|---|---|---|---|---|---|
| Medicine | | | | | |
| Allopathic..... | 54,918 | X | $1,210 | = | $66,454,800 |
| Osteopathic..... | 3,420 | X | 1,209 | = | 4,135,000 |
| Dentistry..... | 20,240 | X | 1,209 | = | 24,469,000 |
| Veterinary Medicine..... | 6,229 | X | 630 | = | 3,924,000 |
| Optometry..... | 3,844 | X | 368 | = | 1,414,400 |
| Podiatry..... | 1,903 | X | 369 | = | 702,800 |
| Total | | | | | $101,100,000 |

FY 77

| | | | | | |
|---|---|---|---|---|---|
| Medicine | | | | | |
| Allopathic..... | 55,753 | X | 1,421 | = | $79,200,000 |
| Osteopathic..... | 3,502 | X | 1,371 | = | 4,800,000 |
| Dentistry..... | 20,849 | X | 1,410 | = | 29,400,000 |
| Veterinary Medicine..... | 6,566 | X | 731 | = | 4,800,000 |
| Optometry..... | 3,950 | X | 304 | = | 1,200,000 |
| Podiatry..... | 1,906 | X | 315 | = | 600,000 |
| Total | | | | | $120,000,000 |

*Formula amount per student proportionately reduced to reflect phase-down to some schools not meeting all conditions of the legislation.

Summary

Based on financial assistance through the capitation activities, schools should be able to maintain enrollments, avoid serious disruptions to the stability or quality of the institutions and address the health manpower goal of eliminating the maldistribution of health professionals by specialty and geographic area.

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Student Assistance | | | |
| Health Service Scholarships.... | $22,500,000 | $35,000,000 | +$12,500,000 |
| Loans..... | 24,000,000 | --- | -24,000,000 |
| Scholarships..... | 3,500,000 | --- | -3,500,000 |
| Loan Repayments..... | 6,000,000 | --- | -6,000,000 |
| Total..... | 56,000,000 | 35,000,000 | -21,000,000 |

Health Service Scholarship Program

The 1977 request of $35,000,000 is an increase of $12,500,000 over the 1976 estimate for the National Health Service Scholarship program. This new program combines the previously funded programs of Physician Shortage Area Scholarships and National Health Service Corps Scholarships into one broadened conditional scholarship program to financially assist students and to serve as a mechanism to address the problems of geographic and specialty maldistribution. Scholarships will be awarded to medical and dental students in exchange for a specified period of federal service in the National Health Service Corps, the Indian Health Service, Public Health Service Commissioned Corps, Bureau of Prisons, U.S. Coast Guard or in private practice in a health manpower shortage area. In 1977, the $35,000,000 requested for this program will support approximately 4,650 recipients.

| | 1976 Appropriation | | 1977 Estimate 2/ | |
|---|---|---|---|---|
| | # | Amount | # | Amount |
| New Awards.... | 1,638 | $11,470,000 | 2,500 | $17,500,000 |
| Continuations.. | 1,103 1/ | 11,030,000 | 2,150 3/ | 17,500,000 |
| Total..... | 2,741 | $22,500,000 | 4,650 | $35,000,000 |

1/ Assumes average costs if $10,000 per scholarships under the current legislative authority.

2/ Assumes average costs of $7,000 per scholarship under the Administration's new legislative proposal.

3/ Includes 810 continuation awards at an average cost of $10,000 and 1,340 awards at an average cost of $7,000 per scholarship.

Student Loans

Loans were previously awarded by the schools to assist students with limited financial resources pursuing careers in the health professions who otherwise would not have been financially able to pursue a medical career. Though this particular direct loan program is being terminated, the student guaranteed loan program in the Office of Education is being expanded. It is proposed that Office of Education annual and total loan ceilings be increased, making this form of financial assistance more accessible. In addition, students may apply for Health Service Scholarships.

Scholarships

Health Professions Scholarships were initially awarded to students of exceptional financial need taking into account their educational and living costs of the year compared with the financial resources available to them. In 1977, the Health Professions Scholarship program has been terminated in favor of a conditional scholarship program requiring the recipient to serve in designated shortage areas or various public health programs for a specific period of time. For this reason, no funds have been requested for this program in 1977.

Loan Repayments

Loan repayment funds have been used for several purposes: (1) to repay sixty percent of educational loans for a recipient who agrees to serve in the National Health Service Corps or to practice in a shortage area, (2) to repay eighty-five percent of educational loans for a health professions student who agrees to serve an additional year in a shortage area. 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. Goals previously sought through this program will be incorporated under the Health Service Scholarship program.

Summary

Training in the health care field is an excellent personal investment which promises very substantial financial returns. Thus, health professions students should absorb a greater portion of their educational costs. Students needing financial assistance will be able to take advantage of a conditional scholarship program requiring the recipient to serve in a shortage area or other public health programs, thus addressing the goal of alleviating the geographic and specialty distribution problems. They can also take advantage of an improved and expanded guaranteed student loan program administered by the Office of Education for graduate level training.

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| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Dental health activities..... | $8,442,000 | ($5,500,000)1/ | -$8,442,000 |

The Dental Health Program has been 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.

1/ Activities formerly carried out under this program are included in FY 1977 in Special Projects under the Physician/Dental Extender and TEAM Program.

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Institutional Assistance: | | | |
| Capitation | $44,000,000 | --- | -$44,000,000 |
| Financial Distress | --- | $1,000,000 | +1,000,000 |
| Advance Nurse Training | 2,000,000 | 3,000,000 | +1,000,000 |
| Nurse Practitioner | 3,000,000 | 7,000,000 | +4,000,000 |
| Special Projects | 15,000,000 | 15,000,000 | --- |
| Student Assistance: | | | |
| Loans | 21,000,000 | 5,000,000 | -16,000,000 |
| Scholarships | 6,000,000 | 2,000,000 | -4,000,000 |
| Traineeships | 13,000,000 | --- | -13,000,000 |
| Loan Repayments | 2,500,000 | 3,000,000 | +500,000 |
| Total | 106,500,000 | 36,000,000 | -70,500,000 |

Institutional Assistance

Capitation Grants--The Nurse Training Act of 1975 authorized a new formula for capitation grants to support educational programs in nursing schools of all types and to maintain 1st-year enrollments of the preceeding year. The program funded 1,090 awards for nursing programs in 1976.

Traditionally, one of the largest types of nursing programs, 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, nursing school enrollments rose prior to the availability of capitation support which suggests that this form of institutional support is not essential. Therefore no funds are requested in 1977.

Financial Distress--The 1977 request for Financial Distress is $1,000,000. 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. Financial Distress grants provide assistance to public or non-profit private schools of nursing. Examples of how the funds requested for this program will be used are: (1) emergency situations such as damage caused by floods, fires, etc. or (2) to maintain the quality of nursing education programs for a limited period pending availability of stable long-term support, or (3) to cover the costs of special efforts required to achieve program accreditation. It is estimated that the $1 million requested will support approximately 10-12 grants in FY 1977.

Advanced Nurse Training--The 1977 request for Advance Nurse Training is $3,000,000. A new institutional support authority was added by the Nurse Training Act of 1975 for grants and contracts to collegiate schools of nursing to plan, develop, operate, significantly expand, or maintain programs for the advanced training of professional nurses to be teachers, administrators, supervisors, or nursing specialists. The most urgent need in nursing is for nurses with the advanced preparation necessary for leadership positions. These funds will support projects to assist nursing education programs in meeting this need. It is expected that 250 students in 1976 and 350 in 1977 will be entering the training programs developed with these funds.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of Projects..... | 10 | 15 |

Nurse Practitioner--The 1977 request for Nurse Practitioners is $7,000,000. A new authority was added by the Nurse Training Act of 1975 for grants and contracts to schools of nursing, medicine, and public health, as well as hospitals and other public or non-profit private entities to plan, develop, and operate or significantly expand, or maintain existing programs for the training of nurse practitioners. Emphasis is placed on training to meet the particular problems of geriatric and nursing home patients, as well as training to provide primary health care in home, ambulatory facilities, long-term care facilities, and other health care insititutions.

The national commitment to equalize access of health care and services underscores the need to concentrate resources on the preparation of nurses who can provide primary care in ambulatory and community settings, through advanced training as specialized nurse practitioners. By expanding the activities and responsibilities of the RN, the nurse practitioner can provide comprehensive health care to individuals, families, and groups in a variety of settings, including homes, clinics, offices, institutions, industry, schools, nursing homes, and others. The practitioner is prepared to assess the health status of individuals, to make decisions about treatment in collaboration with physicians, and to provide routine care, counseling, and teaching to patients and families. Nurse practitioners can substantially extend the delivery of health services in rural and other underserved areas and thus help alleviate the health professions maldistribution problem and bring needed health services to people who are not now getting them. It is expected that 240 students in 1976 and 560 students in 1977 will be entering the training programs developed with these funds.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of projects..... | 12 | 28 |

Nursing Special Projects

There is a strong need to concentrate training resources on the preparation of nurses to provide care in shortage areas and in ambulatory and community settings. To move toward accomplishing this objective, this program awards grants and contracts to assist in the establishment of nurse training programs in academic settings through cooperative merger efforts of hospitals and academic institutions; to develop continuing education and retraining opportunities; to increase the full utilization in nursing of individuals from disadvantaged backgrounds, who other wise would be unable to pursue a nursing career; to upgrade the skills of licensed practical nurses and auxiliary nursing personnel; to effect a more equitable grographic distribution of nurses and specialty skills; and to assist in developing curricula and training programs of nurses for primary and specialized care in pediatrics and nursing homes, emphasizing the special problems of geriatric patients. Through these program efforts, our national goals of increasing the availability of personal health services and promoting preventive health

are can be met more effectively. In FY 1977 it is estimated that 150 projects, both continuing and new, will be supported with the $15,000,000 requested.

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 by allowing students with an exceptional financial need to undertake nurse training. The Nurse Training Act authorizes a program of low-cost loans to nursing students of up to $2,500 a year. The funds requested are intended to provide support to students who have received prior assistance.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of schools | 1,190 | 1,230 |
| Number of students assisted | 26,250 | 6,250 |
| Average per student | $800 | $800 |

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 schools. In 1977, this scholarship program will continue to be de-emphasized and is intended to support students who were prior recipients of such scholarships. The reduction of $4,000,000 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.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of Schools | 1,252 | 1,300 |
| Number of Students Assisted | 6,000 | 2,000 |
| Average per Student | $1,000 | $1,000 |

Traineeships--This program provided financial assistance to registered nurses undertaking advanced education preparation for leadership positions. Traineeships provide stipend, 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 1976, $13,000,000 was available for this program. No funds are being requested in 1977. Students needing financial assistance in the future will have access to the Guaranteed Loan Program in the Office of Education.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of Schools | 136 | -- |
| Number of Students Assisted | 3,000 | -- |
| Average per Student | $4,333 | -- |

Loan Repayments--This program provides for the repayment of nursing educational loans of nurses who agree to serve in a shortage area for at least 2 years or who fail to complete their educational program and are financially disadvantaged or who serve as a professional nurse in any public or non-profit private agency, institution, or organization. A maximum of 85% of any educational loan is repaid if service is for 3 years. It is estimated that 1,000 nurses will participate in 1977.

Summary

The Nurse Training Act of 1975 provides for continued improvement in nurse training. Funds will be directed specifically to improving both the numbers and distribution of nurses prepared for expanded roles in primary care, prevention, and clinical specialties as well as for teaching, administration and supervision. New authorities will provide funds to plan develop and operate or significantly expand or maintain (1) programs for advanced training of professional nurses, and (2) programs that meet established guidelines for the training of nurse practitioners.

Special Project Grants and Contracts

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Family Medicine Residencies and Training | $15,000,000 | $ 39,000,000 | +$24,000,000 |
| Primary Care Residencies and Training | --- | 18,000,000 | +18,000,000 |
| Project Grants and Contracts: | | | |
| Health Professions | 37,583,000 | --- | -37,583,000 |
| VOPP | --- | 8,000,000 | +8,000,000 |
| Public Health | --- | 8,000,000 | +8,000,000 |
| Allied Health | --- | 8,000,000 | +8,000,000 |
| Physician/Dental Extenders and TEAM | 8,000,000 | 16,000,000 | +8,000,000 |
| Geographic Maldistribution and AHEC's | 12,000,000 | 19,000,000 | +7,000,000 |
| Disadvantaged Assistance | 7,286,000 | 5,000,000 | -2,286,000 |
| Foreign Medical Graduates | --- | 2,000,000 | +2,000,000 |
| National Advisory Committee on Graduate Medical Education | --- | 1,000,000 | +1,000,000 |
| Innovation - Start-up Assistance | 3,000,000 | 1,000,000 | -2,000,000 |
| Financial Distress | 5,000,000 | 3,000,000 | -2,000,000 |
| Manpower Initiatives | 11,189,000 | --- | -11,189,000 |
| Total (Budget Authority) | $99,058,000 | $128,000,000 | +$28,942,000 |

Family Medicine Training

The specialty distribution of medical manpower is one of the most complex health issues facing this Nation. It is one that continues to receive major public debate. Citizens are demanding the services of a physician who can provide comprehensive personal health services. The development and expansion of family medicine educational programs is one strategy being used to make these kinds of services available and accessible to those who seek them. Efforts are directed at integrating family medicine in the medical education process at all levels and in community settings. Key to these efforts is also the development of appropriate faculty resources and reimbursement mechanisms for family medicine residency training provided in ambulatory environments. Currently, the reimbursement system favors hospital-based training, therefore service reimbursement is inadequate for primary care training in ambulatory settings. Until adjustments are made in the reimbursement system, it is unlikely that primary care training programs will become self-sufficient. Findings of a recent survey of 1975 family medicine graduates revealed that they tended to be geographically distributed in rough balance to the population. Twenty-four percent are located in non-metropolitan counties. Thus, in addition to helping relieve the specialty problem, the development and expansion of family medicine programs can contribute toward ameliorating physician geographic problems.

The 1977 request for family medicine training is $39,000,000. For family medicine residencies $26,000,000 is requested to continue 143 projects. For other grants and contracts $13,000,000 will be used for the development and establishment of predoctoral educational experiences oriented to primary care, including focus on a core curriculum and model family practice and primary care units, and development of faculty as primary care teachers. Efforts will be directed toward achieving a full complement of medical and osteopathic schools with viable and identifiable units for primary care programs. Currently, about sixty-percent of the operating schools (123) accepting students have such units.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| 1st Year Family Medicine Residents | 1,100 | 1,100 |
| Total Family Medicine Residents | 2,580 | 2,580 |

Primary Care Residency Training

There is a need to promote and assist with the development of additional non-family medicine primary care residency programs in order to foster rapid integration of promising methods into the Nation's health education system. This need will be accomplished by grant support to schools of medicine and osteopathy and to public and private nonprofit hospitals to assist in meeting the costs to establish or expand training programs in general internal medicine, general pediatrics, direct or affiliated residency programs, clinical clerkships, supervised externships, or for faculty development or improvement. The dental primary care residency and training programs will be used to support family dentistry/primary care projects including those for residencies, undergraduate training and faculty development.

The 1977 request of $18,000,000 will support the initial operations and expansion of approximately 64 residency and 10 training programs and for related faculty development and undergraduate training.

This effort is expected to help reach a short-term objective of 200 filled first-year medical residency positions in 1977. This includes adding internal medicine spaces and converting others to primary care focus. The long-range goal is to have half of the first-year residencies emphasize primary care specialties.

Special consideration will be afforded the programs offering substantial educational experiences in ambulatory settings geographically removed from the principal teaching site and in critical health resource shortage areas.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of Projects: | | |
| Medicine | -- | 64 |
| Dental | -- | 10 |
| Residency Years: | | |
| Medicine | -- | 386 |
| Dental | -- | 383 |

Health Professions Special Projects

In 1976 these funds influenced schools to undertake programs of interdisciplinary training, primary care and increase enrollment of minority and women students and initiated new projects addressing problems of specialty and geographic maldistribution.

In 1977 the program support for these projects will be shown under several other programs, namely: family medicine, primary care and project grants for veterinary medicine, optometry, podiatry and pharmacy.

Project Grants and Contracts:

Veterinary Medicine, Optometry, Podiatry and Pharmacy

The $8,000,000 requested in FY 1977 will be used to support grants and contracts (1) to schools of optometry, podiatry, and pharmacy to develop affiliation with Medical, Osteopathy, and Dental schools, to establish relationships with various entities for clinical training, improve curricula, and to provide training in clinical pharmacy and pharmacology; (2) to schools of Optometry, Pharmacy, Podiatry, and Veterinary Medicine to place graduates in areas having critical health manpower shortages. Contracts will be awarded to develop schools which will serve regional requirements for training in optometry and podiatry.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of Projects..... | --- | 90 |

Public Health

Project Grants and contracts for Public Health Training make possible innovative and expanded curriculums in schools of engineering, administration, public health, and other institutions preparing leadership personnel for the emerging management and specialized staff responsibilities in public health. Through these competitive grants, curriculums in health services administration policy and planning have been broadened to include experiences for their students in health and medical care and to increase their potential for dealing with the problems of current and projected health care systems.

These grants and contracts also expand environmental health programs in the administrative and management skills necessary in the solution of environmental health problems. Similarly, they are providing the resources for a transition in the curriculums for the training of specialized staff to include training of the health statistician, epidemiologist, nutritionist, and health educator in new and expanded roles and functions.

Examples of current projects include: development of health services administrators to become competent in the planning and management of health care systems and community health programs; the development of competencies to deal with environmental health services systems; and, development of skills in nutrition--particulary concerning both inner-city and rural problems of malnutrition. The 1977 request is for $8,000,000.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of Projects..... | --- | 110 |

Allied Health

The 1977 request of $8,000,000 will be used to award 109 grants and/or contracts in the priority areas indicated.

Approximately half of the projects are to improve the development of educational methodologies for preparing people to function efficiently and effectively as allied health professionals, improve coordination between and within institutions, and to investigate current and potential roles and functions of Allied Health Professionals.

There exists a great need to continue efforts to (1) improve coordination of educational programs, (2) to further investigate current and potential roles and functions of allied health professions personnel as they relate to improved

utilization, more equitable distribution, changing delivery systems, and access to primary care, and (3) to develop improved educational methodologies for preparing people to function efficiently and effectively as allied health professionals to improve the quality of health care. This involves support for program expansion, curriculum improvements in allied health training, and develop uniform national standards for professional competence, and for advanced training and continued competency.

Priority will be given to programs training allied health professionals in specialties crucial to the support of primary care practitioners, and in specialities that have critical manpower shortages. Other areas that will be emphasized are credentialing standards and development of competencies measurements.

Physician/Dental Extenders and TEAM

This program is comprised of three previously funded activities into one overall program to expand the training of health care extenders to more effectively aid the physicians or dentists (including specialists in care of the elderly) and also to aid in the placement of graduates in practices and institutions in resource shortage areas. These programs are:

(1) Physician Assistants (PA)--The PA program emphasizes the development of physician assistants to serve in primary care settings and in resource shortage areas. Training is completed in a relatively short time period (usually less than 2 years) thereby quickly increasing the availability of health manpower services. Additionally, they are performing many medical tasks traditionally performed by physicians but not requiring their extensive knowledge and skill, thus enabling physicians to expand the scope of their activities and concentrate on more difficult cases.

(2) Expanded Function Dental Auxiliary (EFDA)--The EFDA program is directed toward expanding the role of dental auxiliaries in the delivery of dental services under the supervision of the dentist. The achievement of the training goal is necessary if established practitioners and TEAM trained dental graduates who intend to practice TEAM dentistry are to have sufficient numbers of qualified EFDAs available to work in their practice.

(3) Training in Expanded Auxiliary Management (TEAM)--This grant program ensures that newly graduating dentists have the skills to establish efficient and productive practices which will significantly increase the dental services available to the public. Specifically, the program teaches dental students to work with and manage multi-member teams which include one or more expanded function dental auxiliaries. The goal of this activity is to have TEAM programs operational in most dental schools with ultimate phaseout of federal support in those schools that have had a reasonable amount of time (5-7 years) to make their TEAM programs self-supporting.

The 1977 request of $16,000,000 will support programs oriented in performing the above training functions.

| | 1977 Estimate | | |
|---|---|---|---|
| | PA | EFDA | TEAM |
| Total Amount..... | $8,500,000 | $2,000,000 | $5,500,000 |
| No. of Projects..... | 42 | 16 | 34 |
| No. of Students Trained..... | 2,700 | 845 | 2,000 |

Geographic Maldistribution and AHECs

State-wide and area-wide efforts are needed to coordinate health manpower training with community service needs. The Area Health Education Center program is designed as a system or arrangement that links health service organizations and educational institutions in a way that serves both the student and the surrounding community. Emphasis is placed on clinical training of medical and other health professions students in hospitals and ambulatory care settings in medically underserved areas.

This program expands efforts beyond support of the current AHEC sites to a broader range of activities aimed at ameliorating the effects of geographic maldistribution. The activities included in this program are:

(1) expansion of existing AHEC programs, which has proved successful in providing for trained health manpower in underserved areas;

(2) training of health professionals in geographic health manpower shortage areas. This has proved to be a major influence on their decisions regarding location and practice;

(3) concentration on training health manpower in geographic scarcity areas to redirect their careers to specialty shortage areas and to focus on continuing education;

(4) promotion of community-based AHEC training of health personnel, regional systems of continuing education, and rotation of teaching staffs from health education institutions to community service facilities and programs to upgrade skills of local professionals; and

(5) establishment of data transmission and backup consultation linkages, including computer technology, with remotely-based rural physicians and dentists.

The FY 1977 request of $19,000,000 will support approximately 19 projects aimed at meeting our national commitment of training health professionals in health manpower scarcity areas, upgrading skills of local professionals and addressing the maldistribution of professionals in specialty areas.

| | 1977 Estimate |
|---|---|
| No. of Projects | 19 |
| No. of Sites | 48 |
| No of Students Benefitting | 34,000 - 38,000 |

Disadvantaged Assistance

The 1977 request of $5,000,000 will motivate, recruit, and retain socio-economically and educationally disadvantaged students to receive training in schools of medicine, dentistry, osteopathy, 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 socio-economic factors, are financially or otherwise disadvantaged. Specifically, these awards will be made to public or non-profit 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.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of projects | 50 | 50 |
| Students benefitting | 3,500 | 3,500 |

Foreign Medical Graduates

The entry of Foreign Medical Graduates (FMGS) into the United States during the past two decades has added significantly to the pool of physician manpower but raises serious issues including those of equity and quality. Included in this influx of FMGs are U.S. citizens who, having been unable to enter U.S. medical schools, elect to attend foreign medical institutions. There are approximately 6,000 U.S. citizens presently studying medicine abroad.

In 1971, of more than 25,000 unlicensed FMGs who were engaged in the delivery of health care, only 15,000 were in approved training programs. As a result, it has been estimated that approximately 10,000 non-licensed FMGs work, unsupervised, in the health field and constitute, what has been termed, a "medical underground".

The basic screening device and mechanism whereby FMGs enter approved training programs in the U.S. is certification by, and successful completion of, the Educational Commission for Foreign Medical Graduates (ECFMG) examination. The FMG average pass rate for this exam is 37%, whereas it is estimated that the pass rate of U.S. medical school graduates (USMGs) would be 99%. Many FMGs take this examination repeatedly before passing.

The 1977 request of $2,000,000 will provide for expanded efforts to (1) identify and assist nonfully licensed FMGs, engaged in the delivery of health care, become fully licensed practitioners, and (2) provide U.S. citizens studying in foreign medical institutions opportunities to transfer to U.S. medical schools where they can be integrated into the U.S. medical school system at a relatively early stage of their medical education.

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Number of projects..... | --- | 14 |
| Students/FMGs Benefitting..... | --- | 390 |

National Advisory Committee on Graduate Medical Education

Recognizing the critical and continuous need for analysis and development of alternative policy options to address the maldistribution of physicians, the Department will establish a National Advisory Committee on Graduate Medical Education. This Committee advises the Secretary on issues related to graduate medical education and recommends policy alternatives to achieve a more appropriate distribution of physician specialists. Principal functions include analysis, goal setting, monitoring and evaluation.

Unquestionably, the issues surrounding specialty distribution are numerous and complex. They involve at the least, the establishment of goals and priorities for health and health manpower, data collection, analysis, accreditation, financing, and regulation. Also involved are areas such as foreign medical graduates, and the role of the public and private sectors.

The 1977 request of $1,000,000 would provide for assembly of the Committee, special meetings, commissioning of several position papers, recording of proceedings, development of publications and reports, and the provision of a minimum staff of 3-5 individuals. A nominal amount would support about three manpower analytical studies conducted through negotiated contracts.

Innovation - Start-up Assistance

Start-up grants were 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. The FY 1977 request of $1,000,000 will complete the phase-out of support for three schools who received such a grant in FY 1974.

Financial Distress

Financial distress grants are available to MOD, VOP, and public health schools in financial distress to avoid serious disruptions to the stability or quality in such institutions. Funding of $3,000,000 will be available under this comprehensive special project authority.

Manpower Initiatives

These funds were used to provide training programs leading to more efficient utilization of all types of health personnel, including the recruitment and retention of individuals from disadvantaged backgrounds, and encourage interdisciplinary efforts to provide high quality health care in a cost-effective manner. The program also includes projects in humanistic medicine and projects to train health professions students in the use of the team approach to the delivery of primary health care. In FY 1977, activities formerly conducted by this program are eligible to be carried out under project grant authorities.

Summary

The special project activity revises and consolidates prior authorities for project grants and contracts into a comprehensive special projects activity in order to focus resources on those health manpower activities which we believe are most deserving of support. The areas which we will emphasize are: geographic maldistribution, especially in rural areas and inner cities; specialty maldistribution stressing primary care practice and family medicine training programs; providing interdisciplinary training and demonstrating curriculum innovations; linking training efforts with improved distribution of health personnel in underserved areas; training physician and dental extenders to improve the efficiency and availability of health services; providing assistance to individuals from disadvantaged backgrounds; and assisting Foreign Medical Graduates and U. S. students in foreign schools to improve quality health care for all Americans.

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| D.C. Medical/Dental Schools | $9,050,000 | --- | -$9,050,000 |

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 1976, $9,050,000 was awarded to George Washington University School of Medicine and Georgetown University Schools of Medicine and Dentistry. Funds are not requested for this program in 1977 because the authorizing legislation expired on June 30, 1976. These schools will be able to compete with other health professions schools for funds under other health manpower programs in 1977.

Health Facilities Construction

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Medical facilities..... | --- | $74,260,000 | --- | -$74,260,000 |
| Health teaching facilities grants..... | --- | --- | --- | --- |
| Health teaching facilities interest subsidy. | $2,000,000 | 3,000,000 | --- | -3,000,000 |
| Special medical facilities..... | --- | 7,575,000 | --- | -7,575,000 |
| D.C. medical facilities | --- | --- | --- | --- |
| Total..... | 2,000,000 | 84,835,000 | --- | -84,835,000 |

Medical facilities

The Health Planning and Resources Development Act of 1974 established the Health Facilities Construction program, replacing the Hill-Burton Medical Facilities Construction program. This program is administered by the State Health Planning and Development Agencies and provides Federal financial assistance to the States for modernization of outdated existing medical facilities, for construction of new outpatient medical facilities which will serve as alternatives to inpatient hospitalization, for construction of new inpatient medical facilities in areas which have experienced recent rapid population growth, and for conversion of existing facilities for providing new health services.

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, each 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. This plan must include a list of the projects for which assistance will be sought and the priorities for the funding of these projects.

Twenty-two percent of the funds appropriated are for special medical facility projects designed to eliminate or prevent imminent safety hazards or to avoid noncompliance with State or voluntary licensure or accreditation standards. There must be assurance of 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.

Priority funding under this program is given to rural areas, poverty areas, areas with rapid population growth, projects to eliminate or prevent safety hazards and to assure compliance with State licensure or voluntary accreditation standards, and medical facilities which will provide comprehensive health care. In all cases, the community's need for any proposed use of construction funds is to be established before the funds are committed.

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Impact of 1977

No funds are requested for this program in FY 1977. The significant efforts required to develop agencies, have them become operational including the development and approval of State Medical Facilities Plans will be continued into FY 1977. Thus, for the most part, projects will be funded in FY 1977 utilizing funds appropriated in FY 1976.

In addition, carry-over activities from Title VI such as monitoring of assurances given and payments on construction will be continued during FY 1977. Assistance to facilities programs outside the Department, e.g., Federal Housing Administration, will also continue.

Health Teaching Facilities Construction

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Construction Grants..... | --- | --- | --- |
| Interest Subsidy..... | $3,000,000 | --- | -$3,000,000 |
| Total..... | 3,000,000 | --- | -$3,000,000 |

Health Teaching Facilities Construction Grants

Through this matching grant program, Federal assistance has been provided in the construction of teaching and related library, clincial, and research training facilities for the training physicians, dentists, nurses, pharmacists, optometrists, podiatrists, veterinarians, and professional health personnel.

The $299,138,000 from prior year funds will assist (in 1976) in the construction of approximately 135 projects at health professions schools and approximately sixty to sixty-five nursing school projects. In 1977, no new grant funds are being requested. However, the Nurse Training Act of 1975 provides for loan guarantee and interest subsidies which will be available to assist schools in replacing present facilities, although there has been no demand for such loan assistance. The legislative proposal for health professions provides for loan guarantees and interest subsidy to schools supported prior to July 1, 1974.

Health Teaching Facilities Interest Subsidy

For 1977, the Federal Government will continue to support construction for health professions education and nursing through loan guarantees for private non-profit schools and authority was added for guarantees of loans made by the Federal financing Bank. The Government has the authority to guarantee the full amount of any losses in case of loan defaults.

Under the Nurse Training Act of 1975 and the proposed legislation for health professions the Government may pay to the lending institution an interest subsidy, on behalf of the school, amounts which would reduce the net effective interest rate paid by the school by up to three percent. Health Professions interest subsidy payments would cover payments for only those projects supported prior to July 1, 1974. No funds are requested in 1977 for interest subsidy. The $2,469,000 to be obligated in 1977 is from prior year funds. The total construction value estimated for these projects will be $75,000,000.

Summary

Construction assistance is provided in the form of loan guarantees for the construction and modernization of non-profit private teaching facilities for the training of physicians, dentists, veterinarians, optometrists, podiatrists, and professional public health personnel. Interest subsidies would be continued under previous commitments.

Special Medical Facilities

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Special medical facilities..... | --- | $7,575,000 | --- | -$7,575,000 |

For special medical facilities, $7,575,000 was provided in 1976 to complete construction of Children's Hospital in the District of Columbia, and to support construction of parking facilities for the Georgetown University Concentrated Care Center.

Impact of 1977

No funds are requested in 1977, as the 1976 funds are understood to be the last funds necessary for these projects.

Program Management

| | 1976 Revised President's Budget | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| Personnel compensation and benefits..... | $35,295,000 | $35,295,000 | $36,157,000 | +$862,000 |
| Other expenses..... | 12,705,000 | 13,147,000 | 13,143,000 | -4,000 |
| Total..... | 48,000,000 | 48,442,000 | 49,300,000 | +858,000 |
| Positions. | 1,600 | 1,564 | 1,516 | -48 |

This activity supports the Federal operations and management personnel associated with the HRA programs listed below. 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 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, as well as responsibility for the planning and evaluation of the health resources programs. This segment of the "Program Management" budget includes the program direction activities of the Health 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.

This budget requests 1,516 positions and $49,300,000 for carrying out in 1977 activities associated with "Program Management." This amount includes an increase of $1,689,000 for mandatory costs such as within-grade increases, FTS, postage and telephone charges, and increased costs for rent, and other services. This increase is offset, in part, by a $1,133,000 decrease in non-recurring equipment, one less day of pay, and payments to the NIH Management Fund.

During 1977, the major thrust of the HRA program staffs will be preparation for implementation of the several legislative programs all of which have been recently authorized. These programs include those carried out under the Health Services Research, Health Statistics, and Medical Libraries Act of 1974 and the National Health Planning and Resources Development Act of 1974; the health manpower legislation which is expected to be forthcoming in the spring of 1976.

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Distribution of Program Management Positions and Dollars by Activity

| | 1976 Appropriation | | 1977 Estimate | |
|---|---|---|---|---|
| | Positions | Amount | Positions | Amount |
| National health statistics..... | 44 | $ 1,095,000 | 44 | $ 1,205,000 |
| Health planning and resources development..... | 410 | 12,206,000 | 392 | 12,173,000 |
| Health services research..... | 225 | 6,958,000 | 218 | 7,564,000 |
| Health manpower..... | 618 | 20,137,000 | 596 | 19,884,000 |
| (Nursing activities) * ..... | (55) | (2,039,000) | (55) | (2,039,000) |
| (Dental health activities) * .... | (97) | (3,700,000) | (97) | (3,700,000) |
| Office of the Administrator..... | 267 | 8,046,000 | 266 | 8,474,000 |
| Total..... | 1,564 | 48,442,000** | 1,516 | 49,300,000 |

* Headquarters staff only

** 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)

| 1976 | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 478 | $25,636,000 | $30,000,000 | 478 | $24,000,000 |

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 samples 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 and 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 National, State and local levels for planning, management, and evaluation of health programs.

Explanation: The various health services delivery, health services research, and health planning programs of the Public Health Service require accurate and uniform health data if they are to effectively and efficiently plan, coordinate, conduct and evaluate their activities. Without uniform high quality data these programs would have no accurate or uniform measures of what segments of the population are in need of services, what services or research is required, or what effect the programs are having on the population served in contrast to the population as a whole.

The National Health Statistics Program through direct operations, working through the Census Bureau, and by utilizing contracts with private firms produces 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 for the formulation of national health policies and for the planning, management, and evaluation of health programs at the various governmental levels as well as the private sector.

Accomplishments in 1976: During this year, the National Center for Health Statistics administered and operated the continuous and periodic health and vital statistics activities described above. The first national survey designed to accurately measure total expenditures involved in obtaining health care was begun. The field work for the first Health and Nutrition Examination was completed and the second cycle was begun; reports from this survey were published on dietary intake data, clincial findings, growth and development data, and laboratory test results. Other reports were prepared on prevalence of emphysema, dematologists

findings on the skin disease, data from eye examinations by an ophtalmologists, measures of auditory acuity, assessments of pulmonary function, and a number of other conditions. Data on patient problems and physician diagnosis was published from a survey of patients seen in physicians' offices.

The 16th National Meeting of the Public Health Conference on Records and Statistics was conducted. The meeting which was attended by representatives from Federal, State, and local governments as well as the private sector had as it focus the relationship and utility of available data for health planning.

The Center also conducted national workshops on health manpower data, health facilities data, and confidentiality of data. The workshops dealt with the issues of data needs, data collection, data aggregation, and data sharing among the different governmental levels. The workshops were attended by Federal, State, and local government representatives which are participating in or have an interest in the development of the Cooperative Health Statistics System. There are now 29 States participating in one or more of the data components at the implementation level. There are 10 additional States participating at the developmental level also involving one or more of the data components. The goal of each of the components (vital statistics, health manpower data, health facilities data, hospital care data, long-term care data, and ambulatory care data) of this data system is to provide health data for multiple users (such as Professional Standards Review Organizations and Health Systems Agencies) but collecting and processing the data only once.

Objectives for 1977: The objectives for 1977 are to: (1) continue the operation of the continuous and periodic health and vital statistics activities which produce the various National estimates. At the same time the Center will continue to improve and strenghten the various surveys and to continue its efforts to shorten the time interval between the collection of the data and its subsequent publication; (2) continue those contracts of the Cooperative Health Statistics System which were in the implementation stage in 1976. This involves contracts with 29 States; (3) commence a major reimbursable work program with other Federal health programs by providing them service in the areas of survey design, methodological research, data collection, data processing, and data analysis. Service will be provided to Federal Agencies which have a need for supplementary data which is not available from current data collection programs. Specific activities of this reimbursable work program include collection of new data items by the Center at the request of other programs; conducting followback studies based on earlier Center surveys; conducting special data analysis of available data; providing technical assistance to other Agencies in the design and conduct of surveys; and providing training in statistical methods and data use to personnel of other Agencies. No funds are requested for this reimbursable work program as the program will be funded through reimbursable agreements with Agencies which request assistance.

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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)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $90,000,000 | $296,000,000 | --- | $90,000,000 |

Purpose: Health Planning and Resources Development activities are authorized under Title XV and XVI of the PHS Act, as amended by the National Health Planning and Resources Development Act of 1974. The purpose of this program is to establish and support local and State health planning agencies, centers for health planning, rate review projects, and area health service development projects designed to improve the quality and delivery of health services throughout the nation, contain health care costs, and prevent unnecessary duplication of health resources.

Explanation: The Law provides that fully designated HSAs be funded on a $.50 per capita basis or $3,750,000 whichever is less, with additional funding made available through matching grants up to $.25 per capita, that State agencies receive Federal financial participation of up to 75 percent of their operating costs, and that Area Health Service Development Funds be distributed to health systems agencies in amounts up to $1.00 per capita. Projects for Planning Methods/ Technical Assistance are funded through contracts, and Rate Review Demonstrations are funded on a project grant basis with a maximum of six projects annually.

Accomplishments in 1976: Fifty-six State agencies and 211 local planning agencies are expected to be conditionally designated and funded for their first year of operations to begin preparing and implementing health plans designed to improve the health of the nation. Ten planning centers are expected to be funded through contract awards. In addition, a National Health Planning Information Center will be established which will facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology. The former planning agencies are expected to complete their transition operations and be phased out by the end of FY 1976.

Objectives for 1977: Of the 211 health systems agencies conditionally designated in 1976, approximately 111 will receive full designation and thus assume responsibility for the full range of functions provided in the legislation. The remaining 100 HSAs will be continued for a second and final year of funding under conditional designation. The 56 State agencies will also be continued for a second year. The National Health Planning Information Center established in FY 1976 will be continued. In addition, rate review demonstrations will be established in up to six States.

HEALTH RESOURCES ADMINISTRATION
Health Services Research

Program Purpose and Accomplishments

Activity: Health Services Research (Public Health Service Act, Section 308)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 38 | $26,000,000 | $80,000,000 | 28 | $24,000,000 |

Purpose: The National Center for Health Services Research conducts research to improve the organization, delivery, quality, and financing of health services. The National Center is committed to a research program which will moderate cost and increase access to productive and effective health services.

Explanation: The National Center carries out its activities through three program components: intramural and extramural research, research centers program, and the research training program.

Accomplishments in 1976: The National Center established research priorities and issued program solicitations for research projects in the areas of Long-Term Care and Health Care and the Disadvantaged. Several awards will be made to establish Health Services Research Centers.

Objectives for 1977: The budget request of $24,000,000 will provide for the intramural research program and $18,000,000 for grants and contracts, a total decrease of $2,000,000 from the amount available in 1976. The request will support continuation commitments, including those in Emergency Medical Services research, and will permit several new awards to be made in the areas of Long-Term Care and Health Manpower. The EMS research program was previously funded from the Health Services Administration appropriation and administered by the National Center.

HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: Health Professions Support--institutional assistance (Public Health Service Act, Title VII, Part E)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $101,100,000 | 1/ | -- | $120,000,000 |

1/ Proposed legislation pending.

Purpose: To provide support to health professions schools for maintaining enrollments, and aid in eliminating the maldistribution of health professionals by specialty and geographic area.

Explanation - Capitation: A formula grant, which includes in its computation class size, total enrollments, number of graduates to provide basic Federal support to the educational programs of the Medicine, Dentistry, and Osteopathy, Podiatry, and Veterinary Medicine, and number of MOD schools and students willing to participate in a geographic and specialty initiative.

Accomplishments in 1976 - Capitation: These basic educational grants were awarded to all eligible health professions schools which provide enrollment and fiscal resources assurance. About 225 schools of medicine, osteopathy, dentistry, optometry, podiatry, and veterinary medicine participated.

Objectives for 1977: The capitation request of $120,000,000 continues basic support to approximately 225 schools of medicine, osteopathy, dentistry, optometry, podiatry, and veterinary medicine.

HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: Health professions--student assistance (Public Health Service Act, Title VII, Parts C and F)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $56,000,000 | 1/ | -- | $35,000,000 |

1/ Proposed legislation pending.

Purpose: The Health Service Scholarship program provides financial assistance to eligible students in return for a commitment of future health service.

Explanation: The Health Service Scholarship Program would provide scholarships to medical, osteopathic, and dental students in exchange for service in health manpower shortage areas, the Public Health Service, or other Federal health service. The scholarship recipient would be required to perform one year of service for each year of assistance. The scholarships would be awarded for periods of two to four years in an annual amount of $3,600, plus tuition and other reasonable educational expenses.

Accomplishments in 1976: The participating health professions schools under previous authority awarded loans to about 16,700 students totalling $20,000,000 and scholarships to over 4,000 students totalling $3,500,000. The Health Service Scholarship program supported 1,103 continuation applicants and 1,638 new participants for a total of $22,500,000. The Loan Repayment program supported approximately 1,000 applicants totalling $2,000,000.

Objectives in 1977: In 1977, $35,000,000 has been requested for the Health Service Scholarship Program to continue the support of about 2,150 students and award 2,500 new scholarships. The Health Professions Loan and Scholarship and Loan Repayment programs have been phased out in favor of the broadened conditional Health Service Scholarship program.

HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: Health Professions--dental health activities (Public Health Service Act, Sections 301 and 774)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $8,442,000 | 1/ | -- | ($5,500,000) 2/ |

1/ Proposed legislation pending.

2/ Non-add: Included under Special Projects - Physician/Dental Extenders

Purpose: This activity has been the Federal focus for dental education, practice, and manpower and service research.

Explanation: The dental health program has conducted and provided contract support for a broad array of research, development and demonstration projects and provided 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 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 1976: Thirty-two dental schools received TEAM grant support totalling $5,500,000. 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 32 contracts and 6 agreements totalling $2,742,000. 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 1977: In 1977, this activity is supported under Special Projects - Physician/Dental Extenders and TEAM at a level of $5,500,000.

HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: Nursing support-institutional assistance (Public Health Service Act, Title VIII, Part A)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $64,000,000 | $115,000,000 | --- | $26,000,000 |

Purpose: This activity provides financial assistance to nursing educational institutions or other entities 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 specialize nurse pracitioners.

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.

3. Advanced Nurse Training--These grants and contracts are awarded to collegiate schools of nursing to plan, develop, operated, significantly expand, or maintain programs for the advanced training of professional nurses to be teachers, administrators, supervisors, or nursing specialists.

4. Nurse Practitioner--Grants and contracts are awarded to academic institutions, hospitals, and other entities to plan, for nurse practitioners with emphasis placed on problems of geriatric and nursing home patients, primary health care in the home and ambulatory and community settings.

5. Special Projects--Grants and contracts to nursing schools and other public or non-profit private agencies to plan or develop new nurse training programs, increase educational opportunities for the disadvantaged, improve geographic or specialty distribution, and improve curriculum development.

Accomplishments in 1976: Approximately 1,090 capitation awards were made totalling $44,000,000 to support an enrollment fo approximately 200,000 nurses. No funds were requested for financial distress grants in 1976. Advanced nurse training supported an estimated 10 projects benefitting 200-250 students with the $2,000,000 requested. Approximately 12 nurse practitioner projects were awarded benefitting about 240 students totalling $3,000,000. Approximately 150 nursing special projects for demonstration, innovation and implementation of programs to develop and incorporate new knowledge into nursing curricula and practice were supported.

Objectives in 1977: The request of $1,000,000 in 1977 for financial distress will support approximately 10-12 grants. Approximately 15 advanced nurse training projects, benefitting 300-350 students with the $3,000,000 requested. In 1977

28 nurse practitioner projects benefitting about 560 students can be awarded with $7,000,000 requested. The $15,000,000 requested in 1977 for nursing special projects will support approximately 150 grants and contracts. Priority areas include consortia for continuing education, development of specialized curricula, and primary care programs.

HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: Nursing--student assistance (Public Health Service Act, Title VIII, Part B)

| 1976 Estimate | | 1977 | 1977 Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $42,500,000 | $50,000,000 | -- | $10,000,000 |

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 statuatory 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 1976: The nursing loan program assisted 26,250 students with the $21,000,000 appropriated. Continued assistance, on a phase-out basis, was provided to 6,000 scholarship recipients, totalling $6,000,000. Nurse traineeships supported approximately 3,300 trainees ($4,333 per trainee) at about 136 schools totalling $13,000,000. The nurse loan repayment program assisted approximately 750 students for $2,500,000.

Objectives for 1977: The request for 1977 of $5,000,000 will provide continued support of loans for an estimated 6,250 nursing students. Continued scholarship support totalling $2,000,000 will be provided to approximately 2,000 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 $3,000,000 will assist about 1,000 students.

HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: Special Project Grants and Contracts (Public Health Service Act, section 301, Title VII.)

| 1976 Estimate | | | Budget Estimate | |
|---|---|---|---|---|
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $99,058,000 | -- 1/ | -- | $128,000,000 |

1/ 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 establishement of Area Health Education Centers (AHEC); expand functions and training of physician and dental extenders to provide primary care care in medically underserved areas; 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; to identify disavantaged individuals with potential for education or training in the health professions and encouraging and assisting them to enroll in a school providing health training; and to assist Foreign Medical Graduates and U.S. students in foreign schools in providing quality health for all Americans; to provide for innovative and start up activities; and to maintain financial stability for health professions schools.

Explanation: Contracts and grants support family medicine grants to public or non-profit hospitals to plan, develop, and operate training programs. Contracts and grants are awarded to public or non-profit private health or educational entities to improve the distribution, supply, quality, utilization, and efficiency of health personnel and the health services delivery system. Special projects grants and contracts for VOPP, Public Health and Allied Health provide a program of targeted activities which include support for correcting specialty and geographic maldistribution, expanding training in primary care, increasing admission of the disadvantaged, and expanding training for physician/dental extenders.

Accomplishments in 1976: Family medicine grants supported programs training about 2,580 residents. Eleven Area Health Education Center projects were supported in underserved areas which provided clinical education for medical, dental, nursing, and various allied health manpower students at 27 AHEC sites. Approximately 10,000 medical, dental, nursing and allied health students will have participated in these decentralized training programs. The program of disadvantaged assistance supported 70 projects totalling $7,286,000

Under start-up assistance, grants totalling $3,000,000 were awarded to four schools initially receiving support in prior years. The financial distress activity

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provided assistance to approximately 12 schools which demonstrated critical current financial need.

Objectives for 1977: The family medicine request for 1977 is $39,000,000 and is expected to support training for about 2,580 residents. The primary care residency program totalling $18,000,000 will support approximately 64 residency and 10 dental training programs. The project grant and contract programs for VOPP, Public Health and Allied Health will be initiated to develop affiliations with MOD schools, expand curricula focusing on the needs of the elderly, geographic and specialty distribution projects, promote clinical training with nursing homes, and health agencies, and support program expansion. It is estimated that $8,000,000 in Project Grants and Contracts - VOPP will support 90 projects; $8,000,000 in Project Grants and Contracts - Public Health will support 110 projects; and $8,000,000 in Project Grants and Contracts - Allied Health will support 109 projects. The $16,000,000 for the physician/dental extenders and TEAM program will provide support for about 42 physician assistants projects totalling $8,500,000 training 2,700 students; 16 expanded function dental auxiliary programs totalling $2,000,000 training 845 students; and 34 TEAM projects totalling $5,500,000 training 2,000 dental students.

The estimate of $19,000,000 for the geographic maldistribution and AHEC program will provide for 19 projects at about 48 sites benefitting an estimated 34,000 to 38,000 students. Under the disadvantaged assistance program, the $5,000,000 requested in 1977 will support about 50 special health career opportunity grants benefitting about 3,500 students. The $2,000,000 requested for foreign medical graduates will support about 14 projects and 390 FMG's. An estimated $1,000,000 is requested to support the National Advisory Committee on Graduate Medical Education addressing maldistribution of physicians, including goal setting, monitoring and evaluation and also for the performance of 3 manpower analytical studies. Start-up assistance of $1,000,000 will provide the last year of such support for three schools. The estimate of $3,000,000 for financial distress grants will provide support to 8-9 schools to help them avoid serious disruptions to the stability or quality of such institutions.

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HEALTH RESOURCES ADMINISTRATION

Health Professions Education

Program Purpose and Accomplishments

Activity: D.C. Medical Manpower Act (Public Health Service Act, Title VII)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $9,050,000 | Indefinite 1/ | -- | -- |

1/ Legislation expires June 30, 1976.

Purpose: To support medical & 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 to maintain enrollments.

Explanation: Grants are awarded to D.C. Medical & Dental Schools after recommendation by the National Advisory Council on Health Professions Education for a period of one year.

Accomplishments 1976: The $9,050,000 supported George Washington University School of Medicine and Georgetown University Schools of Medicine and Dentistry.

Objectives 1977: Legislative authority for this activity expires on June 30, 1976. No extension of this authority is proposed and therefore no funds were requested for this activity in 1977.

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Construction

Program Purpose and Accomplishments

Activity: Medical Facilities Construction (Public Health Service Act, Title XVI)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $74,260,000 | $135,000,000 | --- | --- |

Purpose: Medical facilities construction is authorized under Title XVI of the Public Health Service Act as amended by the National Health Planning and Resources Development Act of 1974. The purpose of this program is to provide Federal financial support to the States for new construction, modernization and conversion of medical facilities, including special medical facility projects designed to prevent or eliminate safety hazards and to assure compliance with State or voluntary licensure or accreditation standards.

Explanation: The Statue provides that construction and modernization formula grants be allotted to the States on the basis of population, financial need and the need for medical facilities projects, with an allotment of not less than $1,000,000 to the 50 States, D.C., and Puerto Rico and not less than $500,000 to the four territories. Of the funds appropriated for health facilities construction, 22 percent are to be made available for direct Federal project grants to public medical facilities for use in preventing or eliminating safety hazards and assuring compliance with licensure and accreditation standards. Grants for these special projects may not exceed 75% of the total cost of the project, except that there may be 100% Federal funding if the project is located in an urban or poverty level area. Funds for this program are available for a 3-year period.

Accomplishments in 1976: Among the major tasks of the newly designated State agencies, before an application for assistance under this title is approved, a State agency must have an approved State Medical Facilities Plan which has been reviewed and approved by both the Department and the Statewide Health Coordinating Council. This plan must include a list of the projects for which assistance will be sought and the priorities for the funding of these projects. This activity is currently ongoing in each State. Also, the Federal regulations for this program are scheduled for publication in the Federal Register in early June, 1976.

Of the $74,260,000 appropriated, $57,922,800 will be allotted to the States and territories for new construction and modernization of medical facilities and $16,337,200 will be awarded to fund approximately 6 special medical facility projects.

Objectives for 1977: No funds are requested for this program in FY 1977. The significant efforts required to develop agencies, have them become operational including the development and approval of State Medical Facilities Plans will be continued into FY 1977. Thus, for the most part, projects will be funded in FY 1977 utilizing funds appropriated in FY 1976.

In addition, carry-over activities from Title VI such as monitoring of assurances given and payments on construction will be continued during FY 1977. Assistance to facilities programs outside the Department, e.g., Federal Housing Administration, will also continue.

HEALTH RESOURCES ADMINISTRATION
Special Medical Facilities
Program Purpose and Accomplishments

Activity: Special Medical Facilities (Public Health Service Act, Section 305(b)(3) and 308)

| 1976 Estimate | | | 1977 | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | $ 7,575,000 | 1/ | --- | --- |

1/ Included in overall health services research authorization.

Purpose: Special medical facilities construction is authorized by section 305(b)(3) of the Public Health Service Act which provides for research and demonstration projects respecting the design, construction, utilization, organization, and cost of facilties and equipment.

Explanation: Grants and contracts are authorized for the funding of research and demonstration projects respecting the design, construction, utilization, organization, and cost of facilities and equipment.

Accomplishments in 1976: For special medical facilities in 1976, $7,575,000 was provided to complete construction of Children's Hospital in the District of Columbia, and to support construction of parking facilities for the Georgetown University Concentrated Care Center.

Objectives for 1977: No funds are required for this activity in 1977 as no additional funds are necessary for these 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)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | -0- | $20,000,000 1/ | -- | -- |

1/ Proposed legislation pending for Title VII. Title VIII (Nursing) includes authorization of $20,000,000.

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, veterinary, and professional public health personnel.

Explanation: Construction assistance is provided in the form of loan guarantees.

Accomplishments in 1976: Grant awards for construction of facilities at health professions schools totalling approximately $299,138,000 were made in 1976 with funds available from prior years. These funds supported approximately 135 projects at the health professions schools and approximately 60 to 65 nursing school projects.

Objectives for 1977: No Funds requested in 1977, consistent with the legislative proposal.

HEALTH RESOURCES ADMINISTRATION

Health Facilities Construction

Program Purpose and Accomplishments

Activity: Health teaching facilities--interest subsidies (Public Health Service Act, Title VII, Part B, Title VIII, Part A)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| -- | $3,000,000 | $1,000,000 1/ | -- | -- |

1/ Proposed legislation for Title VII pending. Title VIII (Nursing) includes authorization of $1,000,000.

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: Loan guarantees will remain for the construction of teaching facilities. Interest subsidies will be continued to make payments under previous commitments.

Accomplishments in 1976: Interest subsidy payments estimated at $3,665,000 were made in 1976 against projects for which commitments had been made.

Objectives for 1977: No funds have been requested in 1977, although it is estimated that $2,469,000 in interest subsidy payments will be made against projects for which commitments had previously been made.

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)

| 1976 Estimate | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 1,564 | $48,442,000 | inherently authorized | 1,516 | $49,300,000 |

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 1976: 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 1977: During 1977, the major thrust of the HRA program staffs will be the preparation for implementation of the several legislative programs recently authorized. These programs include those carried out under the Health Services Research, Health Statistics, and Medical Libraries Act of 1974; and the National Health Planning and Resources Development Act of 1974: the health manpower legislation which is expected to be forthcoming in the spring of 1976.

This budget requests 1,516 positions and $49,300,000 for carrying out, in 1977, activities associated with "Program Management." This amount includes a $1,689,000 increase for mandatory costs. This increase is offset by a $1,133,000 decrease in non-recurring equipment, one less day of pay and payments to the NIH Management Fund.

TENTATIVE HEALTH FACILITIES CONSTRUCTION GRANT ALLOCATIONS
FOR FISCAL YEARS 1975, 1976 AND 1977 UNDER P.L.-93-641

| States | FY 1975 | FY 1976 | FY 1977 |
|---|---|---|---|
| Total | | $57,922,800 | |
| Alabama | --- | 1,000,000 | --- |
| Alaska | --- | 1,000,000 | --- |
| Arizona | --- | 1,000,000 | --- |
| Arkansas | --- | 1,000,000 | --- |
| California | --- | 1,801,251 | --- |
| Colorado | --- | 1,000,000 | --- |
| Connecticut | --- | 1,000,000 | --- |
| Delaware | --- | 1,000,000 | --- |
| Dist. of Columbia | --- | 1,000,000 | --- |
| Florida | --- | 1,000,000 | --- |
| Georgia | --- | 1,000,000 | --- |
| Hawaii | --- | 1,000,000 | --- |
| Idaho | --- | 1,000,000 | --- |
| Illinois | --- | 1,290,639 | --- |
| Indiana | --- | 1,000,000 | --- |
| Iowa | --- | 1,000,000 | --- |
| Kansas | --- | 1,000,000 | --- |
| Kentucky | --- | 1,000,000 | --- |
| Louisiana | --- | 1,000,000 | --- |
| Maine | --- | 1,000,000 | --- |
| Maryland | --- | 1,000,000 | --- |
| Massachusetts | --- | 1,000,000 | --- |
| Michigan | --- | 1,017,784 | --- |
| Minnesota | --- | 1,000,000 | --- |
| Mississippi | --- | 1,000,000 | --- |
| Missouri | --- | 1,000,000 | --- |
| Montana | --- | 1,000,000 | --- |
| Nebraska | --- | 1,000,000 | --- |
| Nevada | --- | 1,000,000 | --- |
| New Hampshire | --- | 1,000,000 | --- |
| New Jersey | --- | 1,207,928 | --- |
| New Mexico | --- | 1,000,000 | --- |
| New York | --- | 2,356,674 | --- |
| North Carolina | --- | 1,000,000 | --- |
| North Dakota | --- | 1,000,000 | --- |
| Ohio | --- | 1,125,640 | --- |
| Oklahoma | --- | 1,000,000 | --- |
| Oregon | --- | 1,000,000 | --- |
| Pennsylvania | --- | 1,749,719 | --- |
| Rhode Island | --- | 1,000,000 | --- |

TENTATIVE HEALTH FACILITIES CONSTRUCTION GRANT ALLOCATIONS
FOR FISCAL YEARS 1975, 1976 AND 1977 UNDER P.L.-93-641 (Cont.)

| States | FY 1975 | FY 1976 | FY 1977 |
|---|---|---|---|
| South Carolina | --- | 1,000,000 | --- |
| South Dakota | --- | 1,000,000 | --- |
| Tennessee | --- | 1,000,000 | --- |
| Texas | --- | 1,373,165 | --- |
| Utah | --- | 1,000,000 | --- |
| Vermont | --- | 1,000,000 | --- |
| Virginia | --- | 1,000,000 | --- |
| Washington | --- | 1,000,000 | --- |
| West Virginia | --- | 1,000,000 | --- |
| Wisconsin | --- | 1,000,000 | --- |
| Wyoming | --- | 1,000,000 | --- |
| American Samoa | --- | 500,000 | --- |
| Guam | --- | 500,000 | --- |
| Puerto Rico | --- | 1,000,000 | --- |
| Trust Territory | --- | 500,000 | --- |
| Virgin Islands | --- | 500,000 | --- |

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION
Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Estimate | Transition Quarter |
| 1. National health statistics | $25,636,000 | $6,500,000 |
| 2. Health planning and resources development | 90,000,000 | 16,625,000 |
| 3. Health services research | 26,000,000 | 2,500,000 |
| 4. Health manpower: | | |
| a. Health professions institutional assistance: | | |
| 1) Capitation grants | 101,100,000 | --- |
| b. Health professions student assistance: | | |
| 1) Loans | 24,000,000 | 20,000,000 |
| 2) Scholarships | 3,500,000 | 3,500,000 |
| 3) Loan repayments | 6,000,000 | 2,000,000 |
| 4) National health service scholarships | 22,500,000 | 22,500,000 |
| Subtotal | 56,000,000 | 48,000,000 |
| c. Dental health activities | 8,442,000 | 2,000,000 |
| d. Nursing institutional assistance: | | |
| 1) Capitation | 44,000,000 | --- |
| 2) Financial distress | --- | --- |
| 3) Advanced nurse training | 2,000,000 | --- |
| 4) Nurse practitioners | 3,000,000 | --- |
| 5) Nursing special projects | 15,000,000 | 4,000,000 |
| Subtotal | 64,000,000 | 4,000,000 |
| e. Nursing student assistance: | | |
| 1) Loans | 21,000,000 | 9,000,000 |
| 2) Scholarships | 6,000,000 | 6,000,000 |
| 3) Traineeships | 13,000,000 | --- |
| 4) Loan repayments | 2,500,000 | 1,000,000 |
| Subtotal | 42,500,000 | 16,000,000 |
| f. Special Projects: | | |
| 1) Family medicine residencies training | 15,000,000 | 12,000,000 |
| 2) Primary care residencies training | --- | 2,000,000 |
| 3) Project grants-VOPP | --- | 2,000,000 |
| 4) Project grants-Public Health | --- | 2,000,000 |
| 5) Project grants-Allied Health | --- | 2,000,000 |
| 6) Physician/Dental extenders/TEAM | 8,000,000 | 3,000,000 |
| 7) Geographic maldistribution and AHECs | 12,000,000 | 4,000,000 |
| 8) Disadvantaged assistance | 7,286,000 | --- |

| | 1976 Estimate | Transition Quarter |
|---|---|---|
| 9) Innovation-Start-up assistance..... | 3,000,000 | --- |
| 10) Financial distress..... | 5,000,000 | --- |
| Subtotal..... | 322,328,000 | 97,000,000 |
| g. Medical and dental manpower act of D. C.... | 9,050,000 | --- |
| 5. Health facilities construction: | | |
| a. Health teaching facilities interest subsidies..... | 3,000,000 | 1,000,000 |
| 6. Program management..... | 48,442,000 | 11,130,000 |
| Total..... | 382,820,000 | 134,755,000 |

Explanation

National health statistics--The $6,500,000 will permit the Center 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. This amount includes funds for project contracts for those surveys that will require contract extensions in this period.

Health planning and resources development--During the transitional quarter, agencies funded in 1975 and 1976 will require support. Of the $16,625,000 available, $10,000,000 is needed to fund local health planning agencies, $4,625,000 to fund State agencies, and $2,000,000 to fund contracts for planning methods and technical assistance.

Health services research--The $2,500,000 will provide for continuation funding of the intramural and extramural research programs initiated in 1976 and prior years.

Health manpower--Of the $100,000,000 available, $61,000,000 will be used for student assistance activities including health professions and nursing loans and scholarships and the National Health Service scholarships. These programs are now operating on a forward funded basis which gives the schools the needed time to select recipients. These funds will provide assistance to more than 38,000 students.

The remaining $39,000,000 will support projects that require continuation funding during the transition quarter. Activities continued include family medicine residency training grants, health professions and nursing special project grants and contracts, AHEC's, manpower initiatives and construction interest subsidy payments.

Program management--The $11,130,000 will permit the agency to meet on-going expenses of personnel and related costs at the 1976 operating level during this transition period.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Payment of Sales Insufficiencies and Interest Losses

(Health Education Loans)


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Appropriation Estimate

PAYMENT OF SALES INSUFFICIENCIES AND INTEREST LOSSES

For the payment of such insufficiencies as may be required by the trustee on account of outstanding beneficial interest or participations in the Health Professions Education Fund assets or Nurse Training Fund assets, authorized by the Department of Health, Education, and Welfare Appropriation Act, 1968, to be issued pursuant to section 302(c) of the Federal National Mortgage Association Charter Act, $164,000, and for payment of amounts pursuant to section 744(b) or 827(b) of the Public Health Service Act to schools which borrow any sums from the Health Professions Education Fund or Nurse Training Fund, $3,836,000: Provided, that the amounts appropriated herein shall remain available until expended.

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.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Payment of Sales Insufficiencies and Interest Losses

Amounts Available for Obligation

| | 1976 | 1977 |
|---|---|---|
| Appropriation | $4,000,000 | $4,000,000 |
| Estimated transfer to other accounts[1/] | 4,000,000 | 4,000,000 |
| Health Professions Education Funds | (2,284,000) | (2,727,000) |
| Nurses Training Fund | (1,716,000) | (1,273,000) |

1/ Distribution between Health Professions Education Fund and Nurse Training Fund may vary due to changing interest rate.

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## Summary of Changes

| | |
|---|---|
| 1976 Appropriation | $4,000,000 |
| 1977 Request | 4,000,000 |
| Net Change | --- |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| **Increases:** | | | | |
| A. Built-in: | | | | |
| 1. Cancellations - The $34,000 is needed for reimbursements to schools for estimated loan repayments cancelled under section 744(b) and 827(b) of the Public Health Service Act | --- | $ 1,260,000 | --- | $+34,000 |
| Total, increases | --- | --- | --- | +34,000 |
| **Decreases:** | | | | |
| A. Built-in: | | | | |
| 1. Payment to Treasury - The decrease in interest owed to the Treasury results from a reduction in loans outstanding | --- | $ 1,811,000 | --- | $-34,000 |
| Total, decreases | --- | --- | --- | -34,000 |
| Total, net change | --- | --- | --- | --- |

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Health Professions Education Fund

Amounts Available for Obligation

| | 1976 | 1977 |
|---|---|---|
| Receipts and reimbursements from non-Federal sources | $1,720,000 | $1,735,000 |
| Transferred from other accounts (estimate) | 2,284,000 | 2,727,000 |
| Transferred to participation Sales Fund | -1,185,000 | -1,483,000 |
| Unobligated balance, start of year | 33,881,000 | 32,695,000 |
| Other unobligated balances, end or year | -32,695,000 | -31,213,000 |
| Total, obligations | $4,004,000 | $4,462,000 |

Obligations by Activity and Object

| | 1976 | 1977 | Increase or Decrease |
|---|---|---|---|
| Cancellations | $ 391,000 | $ 841,000 | +$450,000 |
| Interest | 3,613,000 | 3,621,000 | +8,000 |
| Total, obligations | $4,004,000 | $4,462,000 | +$458,000 |

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Nursing Training Fund

Amounts Available for Obligation

| | 1976 | 1977 |
|---|---|---|
| Receipts and reimbursements from non-Federal sources | $ 949,000 | $ 960,000 |
| Transferred from other accounts (estimate) | 1,716,000 | 1,273,000 |
| Transferred to participation sales fund | -790,000 | -980,000 |
| Unobligated balance, start of year | 22,517,000 | 21,727,000 |
| Other unobligated balances, end of year | -21,727,000 | -20,747,000 |
| Total obligations | $2,665,000 | $2,233,000 |

Obligations by Activity and Object

| | 1976 | 1977 | Increase or Decrease |
|---|---|---|---|
| Cancellations | $ 869,000 | $ 453,000 | -$416,000 |
| Interest | 1,796,000 | 1,780,000 | -16,000 |
| Total obligations | $2,665,000 | $2,233,000 | -$432,000 |

Authorizing Legislation

| | Amount Authorized | 1977 Budget Request |
|---|---|---|
| Public Health Service Act: | | |
| Payments to Schools to Cover Certain Costs Incurred in Making Student Loans from Borrowed Fund: | | |
| Health Professions Sch. (Sec. 744(b)) | Indefinite | $ 2,727,000 |
| Schools of Nursing (Sec. 827(b)) | Indefinite | 1,273,000 |

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 | 4,000,000 | 4,000,000 | |
| 1977 | 4,000,000 | | | |

Payment of Sales Insufficiencies and Interest Losses

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation... | --- | --- | --- | --- | --- | --- |
| Other expenses..... | --- | $4,000,000 | --- | $4,000,000 | --- | --- |
| Total..... | --- | $4,000,000 | --- | $4,000,000 | --- | --- |

This appropriation provides for those mandatory interest payments to the Treasury Department and the Government National Mortgage Association which arise from 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 Mortgage 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 1976

The appropriation for 1976 for sales insufficiencies and interest losses is $4,000,000. Included is $1,811,000 for payment of interest to the Treasury Department on $28,987,000 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, $1,260,000 is provided for payment to schools for cancellation 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 1977

In 1977, 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 1977 request of $4,000,000 will provide the following Federal Payments:

$2,542,000 -- Payment of Interest Differential
($1,757,000)-- Health Professions Education Fund
(785,000)-- Nursing Training Fund

$164,000 -- Payment of Insufficiencies
($129,000)-- Health Professions Education Fund
($35,000)-- Nurse Training Fund

$1,294,000 -- Payment of Cancellation
($841,000)-- Health Professions Education Fund
($453,000)-- 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 $28,434,000 (Health Professions Education Fund, $18,484,000 and Nurse Training Fund, $9,950,000) loaned to schools.

$1,777,000 -- Payment of Interest Differential to Treasury
($1,155,000)-- Health Professions Education Fund
($622,000)-- Nurse Training Fund

(2) This category provides for Federal payment to the Government National 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 Mortgage Association as collateral for participation certificates sold to private investors.

$765,000 --Payment of Int. to Govt. 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 to 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.

$1,294,000 -- Payment of Cancellations
($841,000)-- Health Professions Education Fund
($453,000)-- Nurse Training Fund

Payment of Sales Insufficiences and Interest Losses

EXPLANATION OF WHY THERE ARE NO

FUNDS IN THE INTERIM PERIOD

Undisbursed balances in the Health Professions 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. |
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Appropriation Estimate

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

[To carry out section 1622] *For carrying out title XVI* 1/ of the Public Health Service Act, [$10,000,000] *$31,000,000* shall be available without fiscal year limitation for the payment of interest subsidies.

*Further, the principal which may be guaranteed or which may be directly made pursuant to titles VI and XVI of the Act shall not exceed a total cumulative amount of $1,500,000,000.* 2/

[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.] 3/

Explanation of Language Changes

1. Reference to the basic law has been simplified.
2. The amount cited represents a ceiling on the guaranteed and direct loan program at the current level.
3. Language has been deleted which refers to the appropriations of funds for the transition quarter, 1976.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

Amounts Available for Obligation

| | 1976 | 1977 |
|---|---|---|
| Appropriation | $10,000,000 | $31,000,000 |
| Receipts and reimbursements from: Non-Federal sources | 57,954,000 | 36,004,000 |
| Unobligated balance, start of year | 87,163,000 | 76,380,000 |
| Unobligated balance, end of year | -69,976,000 | -58,511,000 |
| Total, obligations | 85,141,000 | 84,873,000 |

Summary of Changes

| | |
|---|---|
| 1976 Estimated obligations | $85,141,000 |
| 1977 Estimated obligations | 84,873,000 |
| Net Change | -268,000 |

| | 1976 Base Pos. | 1976 Base Amount | Change from Base Pos. | Change from Base Amount |
|---|---|---|---|---|
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Interest subsidies on direct and guaranteed loans necessary to honor the interest subsidies for loans already committed and those to be entered into in 1976 under the remaining 1973 loan authorization | -- | $22,130,000 | -- | $+11,970,000 |
| Total, increases | -- | --- | -- | +11,970,000 |
| Decreases: | | | | |
| B. Program: | | | | |
| 1. Direct loans - The decrease in direct loans is the result of no additional loan authority in 1976 and 1977 under Title XII of the PHS Act | -- | 63,011,000 | -- | -12,238,000 |
| Total, decreases | -- | --- | -- | -12,238,000 |
| Total, net change | -- | --- | -- | -268,000 |

Summary of Changes

| | |
|---|---|
| 1976 Budget authority | $10,000,000 |
| 1977 Budget authority | 31,000,000 |
| Net Change | +21,000,000 |

| | 1976 Base | | Change from Base | |
|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount |
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Interest subsidies on direct and guaranteed loans - increase is necessary to honor the interest subsidies for loans already committed and those to be entered into in 1976 under the remaining 1973 authorization | -- | $10,000,000 | -- | $+21,000,000 |
| Total, net change | -- | --- | -- | +21,000,000 |

Obligations by Activity

| Page Ref. | | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| | Interest subsidies | $22,130,000 | $34,100,000 | $+11,970,000 |
| | Direct loans | 63,011,000 | 50,773,000 | -12,238,000 |
| | Total obligations | 85,141,000 | 84,873,000 | -268,000 |

Obligations by Object

| | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Investments and loans | $63,011,000 | $50,773,000 | $-12,238,000 |
| Grants, subsidies, and contributions | 22,130,000 | 34,100,000 | +11,970,000 |
| Total obligations by object | 85,141,000 | 84,873,000 | -268,000 |

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Authorizing Legislation

| | Amount Authorized | 1977 Budget Estimate |
|---|---|---|
| Public Health Service Act: | | |
| General provision relating to interest subsidies (Sec. 626(a)(1).... | such sums as necessary | $31,000,000 |

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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 |
| 1972 | 70,300,000 | 100,300,000 | 100,300,000 | 100,300,000 |
| 1973 | 2,500,000 | 2,500,000 | 2,500,000 | 2,500,000 |
| 1974 | --- | --- | --- | --- |
| 1975 | --- | --- | --- | --- |
| 1976 | 10,000,000 | 10,000,000 | 10,000,000 | |
| 1977 | 31,000,000 | | | |

Medical Facilities Guarantee and Loan Fund

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Personnel compensation | -- | -- | -- | -- | -- | -- |
| Other expenses | -- | $10,000,000 | -- | $31,000,000 | -- | $+21,000,000 |
| Total | -- | $10,000,000 | -- | $31,000,000 | -- | $+21,000,000 |

The Medical Facilities Loan and Loan Guarantee Fund has existed since 1972 under the Hill-Burton Medical Facilities Construction Program. 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 direct loans, loan guarantees, and interest subsidies on guaranteed loans. The fund itself is established in the Treasury, without fiscal year limitations, 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 allotted 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 funds are available for commitment by the States for three years.

The fund consists of $50 million which is restricted for use in fulfilling guarantees in event of default; $30 million which serves as a revolving amount from which direct loans are made; and funds required to provide for interest subsidy payments on both direct and guaranteed loans.

Impact of 1977 Budget

The 1977 request for $31 million is for interest subsidies and is required to honor the interest subsidies for loans already committed and those to be entered into with funds already allotted to the States.

Health Resources Administration
Medical Facilities Guarantee and Loan Fund

Program Purpose and Accomplishments

Activity: Medical Facilities Guarantee and Loan Fund (Public Health Service Act, Title VI)

| 1976 Estimate | | 1977 | |
|---|---|---|---|
| | | Authorization | Budget Estimate |
| Pos. | Amount | | Pos. Amount |
| -- | $10,000,000 | Indefinite | -- $31,000,000 |

Purpose: The purpose of this program is to stimulate and support an increased volume of capital projects for health facilities through the guarantee of loans to nonprofit agencies, the making of direct loans to public agencies, the payment of interest on both guaranteed and direct loans, and the repurchasing of direct loans to public agencies which have been sold and guaranteed.

Explanation: The loan principal authorizations are made available to Hill-Burton State agencies on a formula basis. Interest subsidies are paid on guaranteed loans made to private nonprofit agencies and on the instruments supporting direct loans to publicly owned hospitals. In the case of private nonprofit hospitals, financing is obtained through normal commercial channels. The Government contributes 3 percent of the interest, and guarantees the loan. Loans to public agencies are made directly from a revolving loan fund which is replenished by selling the instruments received as security for the loans, generally bonds, to other investors at a higher, taxable interest rate. Interest subsidy payments are made to supplement the higher interest rate, and the loan instruments bear the full faith and credit of the Government. Loans may be endorsed prior to or upon completion of construction and run for a period of 25 years. These funds are available for a 3-year period.

Accomplishments in 1976: The Loan and Loan Guarantee Fund has assisted 308 projects in 250 communities with a total of $1,180,000,000 ($1,029,207,000 for loan guarantees and $150,793,000 for direct loans).

Uncommitted funds in the amount of $377,073,545 which had been allocated to the States in 1973 were still available for obligation in 1976. It is expected that the States would commit this entire amount before the end of the fiscal year.

Objectives in 1977: Total obligations of $84,873,000 for 1977 include $34,100,000 for interest subsidies and $50,773,000 for direct loans.

The $31,000,000 requested for FY 1977 will be used to pay interest subsidies on loans made under Title VI. Authority to commit loans under this Title expires June 30, 1976.

Transition Quarter Analysis

Budget Authority By Activity

| | 1976 Estimate | Transition Quarter |
|---|---|---|
| Medical facilities guarantee and loan fund: | | |
| Interest subsidies..... | 10,000,000 | 7,000,000 |

Explanation

The $7,000,000 request for interest subsidies for the transition quarter is necessary to honor the interest subsidies for loans already committed and those to be entered into under the remaining 1973 loan authorization.

THURSDAY, MARCH 4, 1976.

## ASSISTANT SECRETARY FOR HEALTH

### WITNESSES

DR. THEODORE COOPER, M.D., ASSISTANT SECRETARY FOR HEALTH
ROBERT MOURE, EXECUTIVE OFFICER, PUBLIC HEALTH SERVICE
DR. S. PAUL EHRLICH, JR., DIRECTOR, OFFICE OF INTERNATIONAL HEALTH, PUBLIC HEALTH SERVICE
LEE SMITH, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, OFFICE OF ADMINISTRATIVE MANAGEMENT, PUBLIC HEALTH SERVICE
PETER J. BERSANO, DIRECTOR, OFFICE OF RESOURCE MANAGEMENT, OFFICE OF ADMINISTRATIVE MANAGEMENT, PUBLIC HEALTH SERVICE
WILFORD FORBUSH, DEPUTY ASSISTANT SECRETARY, BUDGET, OFFICE OF THE SECRETARY
DR. FAYE G. ABDELLAH, DIRECTOR, OFFICE OF NURSING HOME AFFAIRS

Mr. FLOOD. Continuing with the Department of Health, Education, and Welfare, we again have the Assistant Secretary for Health, our old friend, who this committee respects very highly, Dr. Theodore Cooper, the Assistant Secretary for Health. While the committee does not have to do it, for the purpose of the record we will insert your biographical sketch again at this point.

[The biographical sketch follows:]

Name: Theodore Cooper, M.D.
Position: Assistant Secretary for Health.
Birthplace and date: Trenton, New Jersey, December 28, 1928.
Education: B.S., Georgetown University, 1949. M.D., St. Louis University School of Medicine, 1954. Ph. D., St. Louis University, 1956.
Experience:
May, 1975 to Present: Assistant Secretary for Health, Department of Health, Education, and Welfare.
1974 to May 1975: Deputy Assistant Secretary for Health, Department of Health, Education, and Welfare.
1974 to May 1975: Deputy Assistant Secretary for Health
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 Society for Clinical Investigation, 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, Phi Delta Epsilon.

Honors and awards: Distiguished Service Award, American College of Cardiology, 1974 Sixteenth Honorary Lecture Award, Albany Medical College, Albany, 1972. John J. Hammond Lecture, St. John's Medical Center, St. Louis, 1972. Arthur M. Master Lecture, Mount Sinai School of Medicine, N.Y., 1972. Gold Heart Award of the American Heart Association. 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. Research Career Development Award, USPHS, 1962–1966. Who's Who in American Colleges and Universities, 1956. Bordon Award, St. Louis University, 1954.

Mr. FLOOD. I think you may want to introduce your people here.

Dr. COOPER. Yes, sir. I have with me today on my left the Executive Officer of the Public Health Service, Mr. Rupert Moure, and to his left, Dr. S. Paul Ehrlich, the Director of the Office of International Health. To my right, Mr. Peter Bersano, from the Financial Management Office, to his right, Mr. Lee Smith, our Director of Personnel, and to his right, Mr. Wilford Forbush, from the Office of Budget of the Secretary.

I have in addition some other experts with us. For long-term care, Dr. Faye Abdellah, for regional operations, Mr. John Kelso, and others of my immediate financial staff to assist should any questions arise that would need further discussion.

Mr. FLOOD. Doctor, you have a prepared statement. How do you want to handle this?

Dr. COOPER. I would like to read my prepared statement, if I may.

Mr. FLOOD. Very well.

Dr. COOPER. Mr. Chairman and members of the committee, I am pleased to appear today in connection with the 1977 budget request for the Assistant Secretary for Health, the Scientific Activities Overseas and the Retirement Pay and Medical Benefits for Commissioned Officers appropriations.

For the Assistant Secretary for Health appropriation, we are requesting $22,216,000, an increase of $598,000 over 1976 to provide for mandatory costs. There is no increase in staffing.

The 1976 Senate report contained a reduction of $2,446,000 for the Assistant Secretary for Health appropriation and recommended that a portion of the positions in the account be transferred to the various health services, research, regional, and prevention programs. We have achieved a net reduction of 132 positions. The Office of the Assistant Secretary for Health eliminated 36 positions and has transferred 102 positions to the various Public Health Service agencies to be integrated directly with their program operations.

In addition, 11 positions were transferred to the PHS Service and Supply Fund so as to more accurately relate direct service functions with operational activities of the health agencies. Thirteen positions were transferred into this appropriation as a result of decentralization of personnel operations and four positions were transferred in from the general departmental management appropriation in support of the nationwide long-term care enforcement standards efforts.

REGIONAL MANAGEMENT

In 1977, $5.7 million is requested to support the PHS's regional management functions including the regional health administrators and the headquarters staff which provides advice to the Assistant Secretary for Health in matters pertaining to coordination and management of operations in the 10 regional offices. The regional offices activity involves decentralized health programs funded by appropriations of four of the six PHS health agencies. Currently there are 6,000 grants totaling $1.6 billion being awarded and administered in the regional offices.

PROGRAM DIRECTION AND SUPPORT SERVICES

The program direction and support services activity for which we are requesting $14.4 million, provides staff support to the Assistant Secretary for Health in carrying out his managerial responsibilities over the six health agencies and as staff adviser to the Secretary on health matters. Examples of some of the activities in this area are as follows: The Office of Program Implementation has assisted in the resolution of health issues crossing agency lines, between the Public Health Service, medicare, medicaid, and the Office of Human Development—including the problems that arise with regulations which impinge on each system that are promulgated by the Department. This office also supports the resolution of problems through the operational planning system, which permits tracking of progress in our highest priority objectives.

A manual has been prepared and distributed to grant applicants and grantees which summarizes the Public Health Service's grant policies. The grant policies, I might add, are the same for all six agencies. That is to say, they are uniform, which permits grantees to relate to only one set of PHS grant policies.

Support is provided to the Department's medical malpractice efforts, including coordination of the research program and analysis of policy and planning issues.

The forward plan through 1981 was prepared by my staff in cooperation with the agencies and has effectively illuminated the difficulty of clearly articulating any set of general principles regarding the differences between the Federal, State, local, private, and voluntary roles in the health sector. In certain health programs, Federal involvement extends very deeply into specific projects at local levels, while in others it takes a subsidiary role to State and local governments or the private sector. Through the forward plan, we are examining and shaping the major dimensions of the Federal role, without seeking to impose any artificial consistency from one theme to the next.

HEALTH CARE ASSURANCE

A total of $1.5 million is required for support of the health care assurance activities in the Office of the Assistant Secretary for Health. The newly created Office of Quality Standards, as well as the offices of Nursing Home Affairs and Population Affairs provide leadership in insuring that the four determinants of health care quality: effectiveness, safety, cost, and patient satisfaction are present in a quality

assurance process that merges the shared responsibilities of health professionals and Government.

PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

I am delighted to say that Mr. Casey Conrad, the Director of the President's Council on Physical Fitness and Sports program, has also joined us. We are requesting $599,000 for support of the President's Council on Physical Fitness and Sports. The American sedentary way of life constitutes a serious national health problem. Through this program, we seek to promote private support for physical fitness and amateur sports so as to more effectively integrate regular exercise into the normal day-to-day activities of our citizens. I would like to emphasize that I am most concerned about our youngsters in respect to the importance of exercise as a national program of preventive medicine.

SCIENTIFIC ACTIVITIES OVERSEAS (SPECIAL FOREIGN CURRENCY PROGRAM)

We are also requesting in 1977 for the Scientific Activities Overseas appropriation $1.5 million in new budget authority which when added to the prior year funds to be carried forward will provide a total program level of $13.8 million. This appropriation funds selected projects in foreign countries based on reviews for scientific merit and relevance to domestic responsibilities and objectives. Individual projects are selected by the health agencies with overall administrative responsibilities residing with the Office of International Health in the Office of the Assistant Secretary for Health.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

We are requesting $52,352,000, an increase of $7.3 million over the 1976 level for the retirement pay and medical benefits for commissioned officers appropriation. This appropriation covers payments to retired officers and provides 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.

Mr. Chairman, my colleagues and I will be pleased to answer any questions you may have.

1976 BUDGET REDUCTIONS

Mr. FLOOD. Well, Doctor, we are concerned with the way you absorbed last year's budgetary deduction. Can you explain to us why the regional offices lost 70 positions, while your own Central Office here with twice the staff lost only 41?

Dr. COOPER. The reason for that, Mr. Chairman, is that of the 62 positions cut from my central office staff, 36 were essentially outright abolishment of vacancies. This in essence means that there will be no further requirement to employ anyone to perform the functions previously delineated for those 36 positions. The reduction of the 70 positions in the regional management activity was achieved by transferring the entire responsibility and the related staff to the agencies for

carrying out functions that were previously assigned to the regional office staff. The 70 positions therefore reflect the transfer of administrative control to the agencies for activities that are needed to support the public health programs out in the regions.

Mr. FLOOD. Were the regional office positions eliminated?

Dr. COOPER. No, neither the positions nor the functions were eliminated. The responsibility for their location of supervision was transferred to the operating agencies.

Mr. FLOOD. Then you can assure the committee that the regional office will continue to be supported by the agencies.

Dr. COOPER. Yes, sir. And if I have my way it will be expanded somewhat for those special new programs that need technical assistance to service the constituency out in the field. What we have done is absorb the actual elimination of positions in our central office rather than in the regional offices.

### IMPROVING MANAGEMENT IN REGIONAL OFFICES

Mr. FLOOD. What efforts are you making to do something about improving the management of the regional offices?

Dr. COOPER. We have developed over the past 2 years what is called the regional health administrator's work program. This is a device which enables us to work with the regional staff and with the headquarters operational staffs of four of the six Health agencies that have programs in the regions. This program permits us to provide the most service to both grantees and recipients. In that sense, we have achieved a great deal of success in improving the relationships between the headquarters staff, the regional staff, and the people they serve by defining clearly within this document, which we would be pleased to provide to you to show what the work program is. It is the framework around which we can supervise and monitor the activities of the regional office staff.

Mr. FLOOD. Is it still your intention to make the regional offices really a vital part of the decisionmaking processes of the U.S. Public Health Service?

Dr. COOPER. Yes, sir. I have also included representation of the regional health administrators on my own policy board, in addition to the director of regional operations who is on my personal staff. We have increased the delegation of responsibilities to the regional health administrators by including them in the consultation for the policy development and program recommendations for the forward plan for health.

Mr. FLOOD. Have you transferred to these regional offices now responsibility for the administration of additional PHS programs?

Dr. COOPER. I made a commitment earlier this year in legislative hearings to increase the delegation in the HMO programs, the PSRO programs, and the EMS programs. I am presently in the process of implementing those commitments.

### REGIONAL OFFICE STAFFING

Mr. FLOOD. Last year you told us it appeared the regional offices were understaffed when compared to the manpower that you assigned

to all these centralized programs. What have you done to satisfy yourself that the regional offices are adequately and properly staffed?

Dr. COOPER. I have, at some consternation to my agency chiefs, frankly, Mr. Chairman, insisted on a different division of staff to regional personnel in the operation of these programs. I have also insisted on the development of memoranda of agreements and timetables for the delineation of the regional functions for PSRO and HMO responsibilities. We would be pleased to provide you, if you are interested, with our timetables and commitments in that regard. Mr. Chairman, may I add—Mr. Bersano has called to my attention that a total net increase of 90 positions has been made available to regional offices during the period of time since I talked to you last year about this problem.

Mr. FLOOD. All right. You recall last year you inserted in the record a table which compared the regional office staffing to the centralized program staffing. You remember that the ratios ran all over the lot.

Dr. COOPER. Yes.

Mr. FLOOD. Have you developed any standard ratio of manpower, dollars to grants, that you can use to assess the adequacy of the manpower assigned to these various PHS programs?

Dr. COOPER. We have done this as well as we might, sir. Our problem here is that the authorities have not been made uniform enough to achieve this obviously very good suggestion. But, we would like to improve our performance in this regard. For example, in some of the manpower programs, we find ourselves now with one authority that says recentralize and another authority that says to decentralize. And we are trying to work with the legislative committees and with the Secretary's Office in order to clarify some of these problems which would then give us a better management tool for assessing whether or not the ratio that we are using is correct.

Mr. FLOOD. Now, for the record, you might want to go into some detail on that when you get the record.

Dr. COOPER. Yes, sir.

I think this is an important objective, and we ought to be able to make it clear why it takes different dollars to manage different programs with different staff.

Mr. FLOOD. Yes; give us those tables.

[Information follows:]

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The ratios for selected centralized and decentralized grant programs included in last year's House hearings as shown below display a good deal of variance in both the number of grants awarded per man-year and the dollar value of grants awarded per man-year.

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 | 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 |
| 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 expanded | 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.

The reasons for such difference center largely around the differences in the complexity of various PHS grant programs. Some programs for example, which award formula grants annually

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to all 50 States are relatively simple to administer and require small staffs. Other programs face a more difficult task. Some must provide a great deal of technical assistance to develop local capability. Others require a substantial staff effort to impartially and fairly judge a large number of highly technical grant applications. Some programs award a large number of relatively small grants, others award only a few large ones. Because of these fundamental difference in grant programs we have concluded it would be misleading to devise an overall ratio of manpower to grants for all PHS programs. Such a ratio would not adequately take these individual program differences into account.

In order to insure that the regional offices are adequately staffed, we have implemented a PHS Manpower Management Program. Through this program we are documenting the manpower requirements for both central office and the regional offices in implementing the various health programs. We are identifying specific outputs that must be accomplished in implementing each program and the manpower necessary to accomplish these outputs. At the close of this fiscal year we will have documented manpower planning data for all PHS programs. At that time we will be better able to examine the manpower required in central office and the regional offices to implement similar programs.

PERSONNEL RECLASSIFICATIONS IN REGIONS

Mr. FLOOD. We have received numerous letters expressing concern about the personnel reclassifications that are now taking place in the regional offices, their impact upon morale, and so on. How serious is that situation? What impact, if any, is it having upon the efficient operation of the regional office?

Dr. COOPER. Any reclassification actions, which involves downgrades have important morale implications for the staff. And, when the actions are initiated by the Department or the Civil Service Commission in one or more regional office and affect jobs that exist in all regional offices, the potential ripple effect is quite significant. As things now stand as many as 55 employees are threatened with downgrades in region III, over 20 in region IV, nearly 20 in region VI, and a still undetermined number in the other regions.

I too have been receiving a great deal of mail about this situation. As the news of what is happening spreads, the anxiety level rises. Mental health, occupational health, nursing, and similar groups and individuals from the private sector have written or contacted us to express their concerns about the effect on program accomplishment.

I have had and will continue to have discussions with the Office of the Secretary concerning these situations in attempting to minimize the impact on our programs. Also, I have requested review of the classification standards used in making the classification decisions. The employees themselves are prepared to utilize all of their own avenues of appeal.

IMPROVING COORDINATION BETWEEN REGIONAL OFFICES, STATE, AND LOCAL AGENCIES

Mr. FLOOD. In your budget justifications you indicated strong emphasis continues to be placed on improving coordination between the regional offices, the State, and local agencies. What is your effort now in that area?

Dr. COOPER. Well, I think we have, particularly during the past year, received a new mandate which has made the need for communication with State and local officials, with voluntary agencies, with the private sector, and with professional societies more important. I refer here to Public Law 93–641, the National Health Planning and Resource Development Act of 1974, where a very sweeping implication for Federal, State, and local relationships is implied for the allocation of health resources, and for the distribution and approval of Federal grants, particularly in the service and resource area. This has resulted in a significant increase in communication, in technical assistance, and the resolution of appeals made by State and local governments.

Mr. FLOOD. How do you determine if you are succeeding or failing with the effort?

Dr. COOPER. I think the best marker that I have seen is the amount of appeals or concurrences that we have from departmental designation of planning areas, and the amount of competing applications we receive from local organizations.

Now, as you are aware, last summer the Secretary designated some 200 planning areas. We are now in the process of finalizing the regulations and completing the initial review for the selection of health planning agencies. In 174 of those 211 or so planning areas, we re-

ceived only one application. Many of those applications are of the quality that is good enough to reflect the fact that they have addressed a very complex bill, consisting of 16 sections with about 700 pages of regulations and guidelines. I think that this reflects an unusually good degree of communication between the State, the local planners, the regional staff, and the headquarters staff in this regard. This is an excellent indication of good communication—not necessarily agreement, but good communication.

TRAINING NURSING HOME PERSONNEL

Mr. FLOOD. Last year we talked about your program to train nursing home professionals. You remember that?

Dr. COOPER. Yes, sir.

Mr. FLOOD. How are you progressing with this program?

Dr. COOPER. Mr. Chairman, I have Dr. Abdellah with me who can give you the data, as she did last year, on where we stand on the total training effort and our new phase II survey initiative of going from a stage of assessing the safety of the facility to assessing the quality of care and providing the training that is of paramount importance to this program.

Dr. ABDELLAH. Mr. Chairman, there are now a total of 150,000 nursing home providers, including nurses, hospital administrators, and other health professionals, that have been trained. In addition, almost 2,200 State surveyors have been trained. Also, we are currently working with the States to develop a uniform curriculum with common certification applicable to all of them. We see considerable progress in both of these areas.

NURSING HOME CARE

Mr. FLOOD. What other activities are you planning in 1977 that will hopefully result in better nursing home care?

Dr. ABDELLAH. As Dr. Cooper indicated, our major effort in the next few months will be to train additional State surveyors, intermediaries, and providers, in the use of the patient classification system, which essentially focuses upon the provision of those services that are actually necessary. It is a major shift from a paper assessment, which does not mean very much, to really looking at the patients and determining the quality of the care being provided.

Mr. FLOOD. We talk a great deal about it. It is a sound theory. But are you able to get these States to do more, to improve the nursing home situation within their own jurisdictions?

Dr. ABDELLAH. I think we have seen a considerable change in the last 1½ years. The American Health Care Association, which has some 8,000 proprietary members, has voluntarily, on its own, reproduced some materials for training providers, and has requested assistance from the Public Health Service in setting up regional training sessions for nursing home personnel.

HOME HEALTH CARE

Mr. FLOOD. Are you going to use that $3 million for home health services to study ways of reducing our dependence upon nursing homes?

Dr. COOPER. Yes, sir. As you know, when I talked with you during the first of these three budget hearings, we offered this up for rescission. If the Congress decides they will not rescind the money, it is our intention to go forward exactly in the way that the funds were appropriated.

Mr. FLOOD. It did not seem to me you were surprised by that at all.

Dr. COOPER. No, sir; I was not surprised by that. We do believe that there is a need for rebalancing the pattern of health care and resource usage. I believe firmly there is a place for home health care. It is more humane. Costs will be forced upward if we increase the utilization of high cost institutional care. We will therefore utilize what resources you give us to implement home health care demonstrations promptly, to try to demonstrate the best way to achieve good in-home care.

### QUALITY OF NURSING HOME CARE

Mr. FLOOD. In your justifications, you state that the development of the tools to objectively measure the quality of nursing homes is going to be completed in 1976. Have you been successful in meeting your deadlines? And, of course, what impact is that going to have upon the nursing home industry?

Dr. COOPER. The study, which we call our phase II of the long-term facility improvement campaign, is one in which we are participating jointly with medicare and medicaid. It focuses on finding out not so much about the mechanics of whether the door size is right or the window latch is right and so on, which are important for safety, but rather to find out what are the determinants about good humane care, good nutrition, proper use of medicinals, proper personal care, proper physical activity, and human contact. All these things will be in this new survey which, as Dr. Abdellah has pointed out, should be accomplished within the next several months.

From this survey, we will undoubtedly have indications of things that need to be recommended for performance in nursing homes.

Now, the impact on the industry will probably be that in some situations there will need to be modification of their operational style. We would hope this could be done in a prudent, common sense way, and that we do not write spates of regulations which make people robots, or try to make every situation uniform. The focus in our judgment will be how to get good quality care in the setting under which the person finds themselves in the nursing home. But there will be impact, because, as you are probably aware, any survey that has recently been made points out deficiencies.

### INTERNATIONAL HEALTH PROGRAMS

Mr. FLOOD. All right, what are some of the major international efforts that you are planning for in 1977?

Dr. COOPER. I have Dr. Paul Ehrlich with me who can expand on my initial comments. This is an area in which we support the overseas scientific research activities, which are the so called Public Law 480 funds. It is the area in which the Public Health Service participates by representing the Government in the World Health Organization along with serving activities as the focal point for the Department's international health programs as well as for the Government as a

whole. In addition, we are the managers or the supervisors of a large number of bilateral special health agreements which have been entered into by the United States and other countries or in concert with existing international agreements which includes the Soviet Union, Egypt, Poland——

Mr. PATTEN. Ireland?

Dr. COOPER. No, I don't think so, sir. These agreements are developed and reviewed by us very carefully and are designed to achieve not only good quality work, but to further the objectives of the United States as well as serve the people of the participating foreign countries.

Mr. FLOOD. How much of your international program will concern itself with environmental health problems?

Dr. COOPER. Perhaps Dr. Ehrlich can comment on which programs in which countries are addressing themselves to that.

Dr. EHRLICH. Well, we have environmental health programs in all of the various types of international activities that Dr. Cooper has mentioned—multilaterally with the World Health Organization and the Pan American Health Organization, bilaterally in special agreements with the Soviet Union, with Poland, and with Yugoslavia. These endeavors constitute a part of the scientific activities overseas program for which we are requesting an additional $1½ million.

RELEVANCE OF FOREIGN PROJECTS TO U.S. PROGRAMS

Mr. FLOOD. With regard to the delivery of the health services, will this foreign currency program produce comparative studies of our system and that of other countries that are involved in the program?

Dr. EHRLICH. Yes, there are several projects, in fact many projects, which relate to not only comparative studies of health delivery in the United States and in other countries, but which attempt to evaluate or study certain specific parts of that delivery system. For example, in Yugoslavia, we are, as a part of this program, evaluating the value of multiphasic screening as a preventive tool in the health delivery system.

Mr. FLOOD. Name one or two of the more successful foreign currency projects, and their relevance to programs here in the United States.

Dr. EHRLICH. We would be pleased to do so.

Mr. FLOOD. Just touch on those. Then for the record I think you should make quite a record on that.

Dr. EHRLICH. We will be very happy to provide that.

Mr. FLOOD. You might just mention one or two now.

Dr. EHRLICH. An excellent example is a study on leprosy which is currently being conducted and which has been ongoing for several years in India. Leprosy is a specific responsibility of the PHS. As you know, we operate the Carville Leprosarium Hospital. Leprosy is a disease which is difficult to study in the United States because of the low incidence of cases, but in certain foreign countries, where it is highly prevalent, we have the opportunity of looking at it in a unique way. We have been studying the transmission of the disease in anthropods and have demonstrated that a particular mosquito, the Culex mosquito, is able to transmit the bacterium which causes leprosy.

Mr. FLOOD. We would like you to elaborate on that for the record quite a good deal, the relevancy of these programs to the United States.

[The information follows:]

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Relevance of Scientific Foreign Currency Projects
To the United States

All projects supported under the Scientific Activities Overseas (Special Foreign Currency) Program are designed to be of mutual benefit to the United States and the host countries. There are many excellent projects both completed and ongoing which are particularly relevant to domestic health problems and programs. A few examples are given below.

There are a number of diseases in which there is an accumulation of chemically complex fatty substances in spleen, brain cells and other parts of the body due to inborn metabolic errors. These diseases, are called hereditary sphingolipidoses and include Gaucher's, Niemann-Pick, and Tay Sachs disease. The latter has become well known in the United States during recent years because of its prevalence among the children of Jewish parents. For several years funds from this appropriation supported a highly productive study in Israel aimed at learning the nature of the specific metabolic enzymic defects in these diseases. Important accomplishments of this work were the synthesis of two radioactive fatty compounds which led to the identification and discovery of the metabolic defects in Gaucher's disease and Niemann-Pick disease and identified the lesion in Fabry's disease as well. The biochemical abnormality had been the subject of previously unsuccessful investigations for more than 50 years. Additionally, a simple test for the diagnosis of Gaucher's disease and Niemann-Pick disease was developed and two useful chemical intermediates were synthesized for investigating the accumulation of fat related substances in the neuronal cells of the brain of Tay Sachs disease. As a result of this and other fundamental investigations of the underlying biochemical derangements of these diseases it has been possible, for several years, to monitor pregnancies at risk for all of the lipid storage diseases.

A direct responsibility of DHEW is the protection of the American public by assuring the safety of imported food products. The Food and Drug Administration has utilized funds made available under this appropriation to support an ongoing study in Morocco of the "Sanitary and Environmental Factors Related to Contamination of Ground Capsicum (Paprika, Chili Powder, etc.) by Mold Hyphae, and Other Foreign Matter". This project is the first such comprehensive study, conducted by FDA, of sources of particulate contamination of an imported food product and measures for prevention of the contamination. Information and data generated by this project should prove useful to the Food and Drug Administration in carrying out its mission of preventing adulteration of foods and potential health hazards due to contamination introduced by rodents, insects, molds, and other agents of filth and decomposition.

An area of continuing interest to DHEW and to the U.S. health science community generally is the identification of new medicinally important compounds. Several projects supported under the Special Foreign Currency Program have been directed toward this concern. Under an agreement between the National Institutes of Health and the Pakistan Council of Scientific and Industrial Research Laboratories alkaloidal plants used in the unani system of medicine in Pakistan are being studied. The objective is to identify new medically useful compounds, particularly anti-tumor, hypotensive, and psychoactive agents, and other alkaloids. The project has involved active collaboration between the laboratories in Pakistan, the University of Michigan, and pharmacological laboratories in the United States. Another project, which has served as an extension of the National Cancer Institute's drug research and development program, has been supported in India. This project has supported the operation of a laboratory for the preparation and evaluation of native synthetic drugs and plant products as potential anti-cancer agents. Over 1,800 different plant materials have been collected, extracts made, and sent to the United States for examination. More than eighty plants were identified

with confirmed activity against animal cancer. Basic to this endeavor has been the need to acquire, from a spectrum of sources, materials which are suitable for initial development and appraisal in established primary development systems.

Occupational health is an important area of cooperation under the Special Foreign Currency Program. Information obtained from projects supported under this program is useful for the establishment of standards for safe exposure limits to occupational hazards. For example, an ongoing project in Poland is studying the effects of noise and heat on health of workers in the metal industry. Exposure to excessive levels of either heat or noise is known to be detrimental to health and is suspected of having important safety implications. U.S. criteria for standards on permissible levels of heat and noise, which will not compromise the health and safety of the worker, are in preparation. The data from this study will provide needed guidance for deciding what, if any, changes in the proposed heat and noise standards are required when the two stresses are present together in the work site. Other useful occupational health studies receiving support are on the effects of whole-body vibration and exposure to industrial toxic chemicals.

An important domestic responsibility of the Public Health Service, more specifically the National Library of Medicine, is to improve the exchange and utilization of information in the biomedical sciencies. To further this mission, the Library has utilized the Special Foreign Currency Program to fund in Poland a series of international critical reviews and monographic studies on health problems of core interest to the health science communities of both countries. These have included an authoritative analysis of the influence of environmental factors as a causative agent of cancer, and a comprehensive review of all information relating to the biilogical effects of microwave radiation.

The prevention and control of communicable and vector-borne diseases is another important area of domestic concern which has been emphasized under the Special Foreign Currency Program. A project funded last year in Egypt with the potential for early use of results, both in that country and in the United States, is a study of schistosomiasis with emphasis on the effects on the skin. One of the hoped for benefits of this study is a simple skin test to diagnose schistosomiasis. This disease is endemic in Puerto Rico and each year the Center for Disease Control diagnoses the disease in several Americans returning from abroad. The results of the study in Egypt may be useful in the diagnosis/screening program at CDC as well as to other U.S. organizations which have personnel stationed in countries where the disease is endemic.

LEPER PROJECT IN INDIA

Mr. PATTEN. Mr. Chairman, at that point, I have a question.

I am wondering, as you mentioned the project in India, whether you have personal knowledge of it, or you are just passing on something you read.

Dr. EHRLICH. I have not personally visited the project. But we have followed its progress and the results. It is being conducted by the Bureau of Medical Services of the Health Services Administration, as a complementary effort to the research program they have in the field of leprosy.

RETIREMENT PAY AND MEDICAL BENEFITS

Mr. FLOOD. Let's return to the "Retired pay account" for a while. Here you show an increase of $3,441,000 for dependent medical care. How much of that is attributed to inflation, and how much is due to the increase in the patient load?

Dr. COOPER. About 11 percent is due to inflation, and about 3 to 4 percent is due to the increase in patient load.

Mr. FLOOD. Suppose you tell the committee why should we appropriate funds to cover this dependent medical care for Coast Guard retirees in the light of your request to transfer the cost of providing medical care for active duty personnel over to the Coast Guard appropriation.

Dr. COOPER. I included the request here to assure continued operation of the program, notwithstanding the recommendation we made in another session that requires legislative consideration. If the legislative recommendation that we transfer this responsibility to the Department of Transportation is not accepted, we have the continuing responsibility to carry through with our commitments.

Mr. FLOOD. I was thinking of the possibility of discussing with OMB the budgeting of these costs to the Transportation appropriation.

Dr. COOPER. I think that is another option. I guess there are really three different options:

One, to continue it; two to charge it to them; and three, to transfer the authority.

Mr. FLOOD. Have you talked to the OMB people about that at all?

Dr. COOPER. We have discussed this particular problem with our Comptroller, and with the Office of Management and Budget for several years.

RETIREMENT PAY PROJECTIONS

Mr. FLOOD. Do you have any long-term projection of the costs of the retirement pay and medical benefits accounts based on the current strength—and recruitment, of course.

Dr. COOPER. Well, Mr. Lee Smith is our Director in this area, and I am sure he has some feel for the area. I personally have not seen a long-range projection of what the ultimate escalation would be beyond 1977.

Mr. FLOOD. For the record, would you estimate the cost for 5 years, 10 years, and for 20 years.

You can do that for the record.

[The information follows:]

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LONG-RANGE COST PROJECTIONS FOR RETIREMENT PAY AND MEDICAL BENEFITS

| Fiscal Year | Retired Officers | Average Cost Per Officer 1* | 2** | Cost Total in Thousands 1* | 2** |
|---|---|---|---|---|---|
| 1977 | 1,568 | 17,122 | 17,122 | 26,848 | 26,848 |
| 1982 | 1,853 | 17,122 | 22,910 | 31,727 | 58,790 |
| 1987 | 2,138 | 17,122 | 30,657 | 36,606 | 78,263 |
| 1997 | 2,708 | 17,122 | 54,896 | 46,366 | 125,559 |

| Fiscal Year | Survivors | Average Cost Per Survivor 1* | 2** | Cost Total in Thousands 1* | 2** |
|---|---|---|---|---|---|
| 1977 | 139 | 5,158 | 5,158 | 717 | 717 |
| 1982 | 189 | 5,158 | 6,900 | 975 | 1,304 |
| 1987 | 239 | 5,158 | 8,232 | 1,233 | 1,967 |
| 1997 | 339 | 5,158 | 14,720 | 1,749 | 4,990 |

SUMMARY TOTALS

| Fiscal Year | Cost in Thousands 1* | 2** |
|---|---|---|
| 1977 | 27,565 | 27,565 |
| 1982 | 32,702 | 60,094 |
| 1987 | 37,839 | 80,230 |
| 1997 | 48,115 | 130,549 |

1* Assuming inflation leveling
2** Assuming inflation at 6%

IMPACT OF CLOSING THE PHS HOSPITALS

Mr. FLOOD. Have you projected the impact on the retirement benefit medical accounts if we close these PHS hospitals, as is proposed in the 1977 budget?

Dr. COOPER. Yes; I have studied this rather thoroughly. I recognize when the hospitals operate at 69 percent occupancy, the perception here is one of less than optimum efficiency. And yet I feel that the quality of care is fine. We would expect in closing the Public Health hospitals that people would have access by choice to other types of care, probably an equivalent community service that is available for purchase by contract. My guess is that the cost to purchase care will be greater in the current market. And I think that will be the most important impact that you will see.

Mr. FLOOD. Well, since you have said that, suppose you tell us the impact on this account if we close the hospitals.

Dr. COOPER. The impact on this account will be that it will increase.

Mr. FLOOD. Well, for the record I think you better set that up because you can be sure about that attracting attention.

Dr. COOPER. Yes, sir. I would just say for the record also, Mr. Chairman, that inflationary costs of 11 percent for inpatient care in this setting is well within the performance of the total private sector.

[The information follows:]

Based upon the assumption of continuation of outpatient services at the sites of present PHS hospitals and the health manpower needs to staff these continuing facilities it is estimated that an additional 110 retirements would occur. Thus our projection of 1,568 retirees in fiscal year 1977 would be increased by this addition to 1,678.

The increased cost of the added 110 retired officers is projected to be $2 million.

The medical care portion of this budget has been projected to increase by approximately $7.4 million should the proposal to close or transfer the PHS hospitals be accepted. The health services appropriation is presently $5.8 million for medical care and the resulting increase is, therefore, $1.6 million.

PHYSICAL FITNESS PROGRAM

Mr. FLOOD. Mr. Patten.

Mr. PATTEN. Dr. Cooper, it is always a pleasure to meet with you at these hearings.

Dr. COOPER. Thank you, sir.

Mr. PATTEN. I have tried to understand just where you are at now, what you are doing here with this budget.

Couldn't we eliminate the $600,000 for the physical fitness?

Dr. COOPER. No, sir. I do not recommend that. One of the most difficult areas for me to get total impact on, including my own children or myself at times, is that of preventive medicine. Our attempts at public health education have not been stellar successes.

Although we can criticize our health education activities to some extent, and question how many people pay attention, this effort, for this price, in my opinion, is a very important one. It helps to keep physical fitness in the minds of people. This is crucial in an era where we are doing more riding and less walking. Lack of physical exercise contributes significantly to the lack of good health.

Mr. PATTEN. You do not have to tell me. When I was mayor I put in more tennis courts, built stadiums to play ball. As far as our getting

into shape compared to the Russians—they put them out, the Chinese put them out. They are beating us in everything, are they not?

Dr. COOPER. Not everything. And I am not advocating that we make people do things. I think it ought to be freedom of choice. One of the best tools we have is the stimulus that can come from the President's Council on Physical Fitness.

INTERNATIONAL HEALTH AGREEMENT

Mr. PATTEN. That is good enough for me.

On using this fake money we have in Egypt and these other places. In Egypt, I talked to a doctor, heading an American expedition—I don't know if he gets any support from HEW. I did not feel that we were getting anywhere. I know when Mr. Sadat came here, he did not ask for penicillin, or streptomycin, or nurses or medical people. He wanted guns.

Dr. COOPER. I think probably obscured in all the discussions of the total agreement that was signed by Minister Fahmi and Dr. Kissinger several months ago, was the area of health which is most important.

Mr. PATTEN. Didn't Sadat come and visit your facilities and ask you for a little health service?

Dr. COOPER. His ministers came and negotiated with us as part of a five-part program, a major agreement in health. And we are making progress there. As you are probably aware, there is a substantial history of productive involvement there at the Navy Laboratory. You mentioned last year that you visited that facility.

Now, the areas that we have agreed to work with them involve public health problems, which address some of the issues that the chairman raised about their system. This includes issues related to our ability to reach the deprived people in the rural setting, to insure that the quality of medication which they are not able to make themselves are of high quality, and to help them perform self-service evaluations for themselves.

That five-part program involved a modest discussion on research, and a significant discussion on how to develop and sustain their own health manpower. During this first year of operation this has been a reasonable and responsible cooperative venture and the costs have not been high.

Mr. PATTEN. Nothing further, Mr. Chairman.

TRANSFER OF REGIONAL OFFICE STAFF

Mr. FLOOD. Mr. Early.

Mr. EARLY. Thank you, Mr. Chairman.

Doctor, with regard to your comments to the chairman on the transfer of personnel, transferring 70 persons from the regional offices, and only 40 persons from the central office; in your statement you said that this is not a decentralization of the regional office.

Dr. COOPER. No, sir. What I was trying to say, when I said that we transferred 70 positions in the regional offices, was that we did not fire those people or abolish their positions. I interpreted the chairman's question to be, was I in fact decreasing the service to the constituency in the regional office at a greater ratio than I was decreasing my own

central office staff. The point I was trying to make was that 36 of the 62 positions reduced from my central office staff were actual abolishment of positions that were vacant, whereas in the regional office, I transferred the responsibility for the supervision of the rgeional office staff people to the line operating health agencies as requested in the Senate report.

Mr. EARLY. How many of those 70 in the regional offices were vacancies?

Dr. COOPER. None. There were no decreases at all in the total staffing in the regions. All of the decreases came out of my headquarters office. The Senate report asked us to return positions to the agencies and to decrease our responsibilities stemming from the PHS reorganization of about 3 years ago, where the perception was that we had created a big administrative layer at the expense of the personnel needs of the agencies. I would like to reemphasize that we did not reduce the regional offices staffing. However, we have continued to review the manpower requirements for the Assistant Secretary for Health appropriation. In light of those reviews we reduced the staffing from 796 positions in 1974, to 765 positions in 1975, and finally to only 633 positions in 1976 as mentioned in my opening statement.

Mr. EARLY. What are the six regional offices?

Dr. COOPER. There are 10 regional offices. They are located in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, Seattle, and San Francisco.

FEDERAL, STATE, AND LOCAL RELATIONSHIP

Mr. EARLY. In almost all those cities if you cut back service, those cutbacks will not be picked up by the States.

Dr. COOPER. Correct. We are not cutting it back. What I have done is transfer from my account to the six line agencies the responsibility for those people who manage the grants in their programs.

Mr. EARLY. I can only speak for Boston. I have not witnessed a very good relationship between the Federal and the State agencies in the past few years.

Dr. COOPER. I think we have continually recommended, Mr. Early, last year and the year before, and as part of the block grant proposal this year there has been a general withdrawal of the Federal contribution in the health service programs in the areas. And this does not foster good relations between Federal agencies and the State and local officials, particularly when we have recommended in past years that the deficit be picked up by the State or local government.

I think despite that, in the past year, because of the willingness of the State and local governments to make a real effort to implement Public Law 93-641, the National Health Planning and Resource Development Act of 1974, that the communication between the regional office staff and the State and local governments has increased and improved. But they are not happy with us, mainly because of the funding level that is being discussed.

Mr. EARLY. Right. But it only appears to have improved because it was so bad before. Whatever you did would have been an improvement.

Dr. COOPER. I think we have to make every effort to go forward on that.

NURSING HOME CARE

Mr. EARLY. With regard to your comments on high-quality care in the nursing homes, you stated that you wanted to improve care quality in a prudent, commonsense way. That implies that in the past, on the Federal level, it has not been done in a good, prudent, commonsense way. Your office went into the nursing homes across Massachusetts with a whole list of criteria, and those nursing homes that were running an efficient operation got the same criticism, the same abuse, the same hardships imposed upon them as those you should have been correcting. Is that going to be improved?

Dr. COOPER. I hope so, Mr. Early. I think some of this is very difficult to handle. If I may give you an example, the first time there would be a fire in one of those facilities with a loss of life, and if we were not applying and trying to enforce the standards, we would be instructed, indeed, as we were in the past, by the Congress, to shape up. Further, I would be in front of Senator Moss, explaining how I could do such a sloppy job. Now, somewhere in between the two extremes we ought to be able to find a way, with the support of the Congress, to make judgmental decisions on quality care that is reasonable. I think we have gone to such an extreme in codification that it results in the perception of excess that you have just described.

Mr. EARLY. Doctor, you can do your job or you can have standards based on statistics, which I think we have altogether too much of. I visited every nursing home in Massachusetts in the former position I held. And I say nursing homes where they provided excellent service to the constituent, just totally abused by the Federal hardships. Nothing was taken into consideration. First of all, the inspectors did not know what they were doing. They went in there with statistics. Some of these homes had never had a fire. You get a home that is in operation for 20 years—and then you say you have to put in five new fire escapes. This just was not what I would call a commonsense way to bring about quality care.

Dr. COOPER. I agree, we would like to improve that.

NURSING HOME CARE STANDARDS

Mr. EARLY. On the complementary side, 2 years ago you imposed some Federal standards on your investigators, that were incorporated in 1974 or 1975. They have promoted a commonsense approach to these problems. And there hasn't been the checkoff list type of approach we witnessed in the past.

Dr. COOPER. That is the program that Dr. Abdellah was talking about. With the support of the committee, we have trained a large number of people ourselves to try to help resolve that kind of situation.

Mr. EARLY. I am speaking of the program that was combined with public safety.

Dr. ABDELLAH. Yes, sir. I was in Massachusetts the week before last. The major problem in that State is the large number of wood frame structures. In many of the facilities that I visited, the quality of care was excellent. But what we are up against is meeting the requirements of the 1967 Life Safety Code.

We recently issued in cooperation with the Office of Facilities Engineering and Technical Improvement, guidelines which would provide ways in which one could waiver this. However, we have held to the main criterion that the health and safety of these individuals must be protected. For instance, we have opposed putting on the third floor those individuals in wheelchairs, who are unable to get out under their own mobility.

Mr. EARLY. This waiver you speak of, will that allow you the flexibility to take every case on an individual basis?

Dr. ABDELLAH. Yes, sir. We have insisted that each case be reviewed individually. We have developed good relationships with State officials. One of the experiments we are trying out in Massachusetts is the reduction of the paperwork in that State. The State of Massachusetts, on its own, has come up with a very innovative approach, a way of getting closer to quality care. We hope in our phase II survey to include the State of Massachusetts in this experimentation, which would reduce the 68-page survey form to a two-page abstract. Essentially, this would free up more time for the State surveyors to spend in providing consultation and technical assistance to the nursing home operators.

Mr. EARLY. You are saying there will be a change from the 68-page questionnaire.

Dr. ABDELLAH. This is one of our goals. The 68-page survey form will be modified to place more emphasis on patient needs, services rendered, and patient outcome rather than the emphasis on institutional capabilities. An abstract of this report will be made consisting of about two pages.

Mr. EARLY. Then I think you might be able to achieve a more commonsense approach.

Dr. COOPER. It would permit us to get more efficient use from the decreased number of positions we are asking for.

### MEDICARE AND MEDICAID FINANCING

Mr. EARLY. Doctor, Massachusetts has tremendous fiscal problems. They have backed out of several programs with the Federal Government. The State talked last year of withdrawing from this particular program. What would happen if they withdrew?

Dr. ABDELLAH. Under the medicaid program; which is presently a matching 50 percent for Federal and State; for those facilities, the State could pick up the total amount. We hope that won't happen, because we feel that the partnership between the Federal Government and the State is very important.

Dr. COOPER. We would not be allowed to pick up all of medicaid.

Mr. EARLY. Is that program funded under medicaid?

Dr. COOPER. Yes. The medicare ones are picked up, but the larger percentage is in the medicaid.

Mr. EARLY. With regard to nursing homes, Doctor, I will say that in the past 18 months in Massachusetts, that new program, Mr. Lampkin, I think, is the State administrator, has been a better approach to providing better service, and a better approach to allowing the nursing homes a chance to stay in business.

Dr. ABDELLAH. Yes; we have been very encouraged there.

COST OF PHYSICAL FITNESS PROGRAM

Mr. EARLY. One final thing.

Dr. Cooper, in answer to Mr. Patten's question on the President's Program on Physical Education. How much of that $598,000 do you use for salaries?

Dr. COOPER. Approximately $350,000.

Mr. EARLY. So you are really spending, other than salaries, only $240,000 on other.

Dr. COOPER. On other preparation of materials, audiovisuals, programs, yes, sir, program development.

Mr. EARLY. The results you speak of, aren't they really the results of maybe 1970, when HEW made a tremendous output on physical education, when they insisted on it in the schools, and they wanted it mandatory?

Dr. COOPER. Let me say if I gave the impression that I was satisfied that there were good results, I want to correct that because I am not. There was an increment in performance as a result of the Department's effort in the early 1970's. There has been, as with many other programs, whether it be cigarette smoking, VD, or other sexually transmitted diseases, a perceptible decrease in awareness and participation when we back off at the Federal level. Now, I think all the things that are included in Ken Cooper's book on aerobics coupled with other health and a whole lot of other preventive measures have contributed to a growing, and I am delighted with it, awareness of the need for physical exercise. I think the President's physical fitness program, particularly with the schools complementing the departmental initiative at that time, which is no longer a perceptible visible effort, has been an important sustaining force.

Mr. EARLY. It has been, Doctor.

But now, as States are running into fiscal trouble, and the blame is being put on education—I would think when States are cutting back on physical fitness programs, that the Federal Government should be picking up the slack. Just as in other areas of the education budget, the feds are reducing and the States are expected to pick up the added costs. I cannot understand how a Federal program, funded for 50 States, for every school, at $598,000, $240,000 of which is salary, can possibly produce anything.

Dr. COOPER. Well, my interprepretation would be frankly just the opposite. If we were to try to take that $600,000 and redistribute it by State to all the schools, the net yield or impact on any increment in their programmatic activity would probably be negligible.

IMPACT OF PHYSICAL FITNESS

Mr. EARLY. Just like I think it has to be negligible with this amount of money.

Dr. COOPER. No. I think some of the activities that are properly done here can have tremendous impact. If I may give you a different example—a $1 million high blood pressure program was started with the support of the committee 3 years ago. The Federal effort in high blood pressure education authorized only $1 million. If we tried to spread that out at that time, or eliminate it because we did not think it would make any impact, we would have done nothing. In the mean-

time, there has been specific reductions in the stroke rate. This was achieved by adequately treating 5 million more people and detecting the tendency in probably 9 million more.

Now, that kind of efficiency is achieved by multiplying the Federal commitment with the participation of the private sector, access to the media, and things of that order which we cannot buy at that cost unless we had a tremendous appropriation for that kind of activity. So that the core of money here is the thing around which a multiplier effect is done, and our net yield is important.

Mr. EARLY. I agree with all that, Doctor. But again, you have your rent, expenses, utilities. It is going to eat that up. No matter what you come up with, you are not going to have money for stamps to send out the information.

Dr. COOPER. But we do in that budget, Mr. Early. What we get for staff purposes, plus the mailings, the development and utilization of new audiovisual support, and new guidelines is coupled with a private effort into which we plug, which probably runs at $40 million, for that particular program. But, our withdrawal from it would be a perception that PHS and the Federal Government no longer consider this important, which would in my opinion, result in a negative effect.

Mr. EARLY. Doctor, will you identify where the $40 million from the private sector is?

Dr. COOPER. Sure. We have a list here, and we will give it to you. You want me to say it now?

Mr. FLOOD. You can provide it for the record.

Mr. EARLY. Just for the record.

I have no further questions.

[The information follows:]

*Sources of non-PHS contributions in support of the national physical fitness program*

| | |
|---|---|
| 1. Public service advertising | $29,000,000 |
| 2. Prudential Insurance Co. of America | 685,000 |
| 3. Montgomery Ward & Co | 124,000 |
| 4. Travelers Insurance Companies—Hartford, Conn | 840,000 |
| 5. General Foods Corp | 800,000 |
| 6. Campbell Soup Co | 25,000 |
| 7. National Collegiate Athletic Association | 6,439,000 |
| 8. National Varsity Club | 1,033,000 |
| 9. Presidential Physical Fitness Award and State champion project | 378,000 |
| 10. Presidential sports awards | 58,000 |
| 11. Readers Digest | 12,000 |
| 12. Regional physical fitness and sports clinics | 90,000 |
| 13. Medical symposia | 18,000 |
| 14. Administration on Aging | 289,000 |
| 15. Office of Education | 169,000 |
| 16. Contributed services of private individuals and associations | 78,000 |
| Total | 40,038,000 |

INTRODUCTION OF VISITORS

Mr. FLOOD. Mr. Patten.

Mr. PATTEN. Mr. Chairman—I have some wonderful women—business and professional women are here to visit the Congress. We had breakfast with them, doctor. They are from all over the State. I wonder if you women would stand up, and show them how lovely you

are. They are mostly from my area. They dropped in last year to visit our committee.

SPIRALING NURSING HOME COST

Regarding these nursing places?

I ran around in 1931—when we had the "Old Age Assistance Program"—that was No. 1 on the totem pole. You had to get an agreement to reimburse, if they owned a house, if they were going to get the little help. It was like relief.

Now—I don't think you were born yet, Doctor.

Dr. COOPER. I know the program.

Mr. PATTEN. Now, my people cannot afford to send their people to a nursing home, because it costs $12,000 a year. You have to have a fire-resistant building at $40,000 a room—it is a far cry from homes that took care of people at $6 a day, and did the job.

John F. Kennedy Hospital tells me they cannot get their patients out and into a nursing home. The nursing home is setting up quotas of 5 percent for those who are on medicare. The hospitals tell me they are losing thousands of dollars, because the nursing homes don't take medicare recipients.

Just one more thought. There is a home which HEW supported in Perth Amboy; it is supposed to be a halfway house. If you go there now, it is full of New York City residents. It is no halfway house. It is a nursing home, because New York City will throw in a couple of bucks.

Dr. COOPER. I know.

NURSING HOME STANDARDS

Mr. PATTEN. My people are not in there.

I've got to say no to my people. It is no longer within reach. I tell you—if your father has to go to a nursing home in my area, you better have $200 a week ready.

Dr. COOPER. What I would like to say is that we really do want to be reasonable about this. We really do regard that the quality of life is much more than whether it is fireproof or not. But we do have legislation under which we have to operate on the 1967 requirements, which if we do not enforce, another committee brings us up here and say, "You will do it," and that is that.

Now, this is how we got to where we are.

I am quite anxious, as a matter of fact, to work with the Congress and with the other agencies in the Department to try to reach a common sense method of insuring a sensible method of use of a balanced system.

I do think it is inappropriate, when we are under court order here in the District—why aren't we getting people out into midway facilities, and we are not doing it. It is not only in Massachusetts, as you say. It is a problem all over. We very much feel that we have to rethink how this is being done. But it must be not an effort by the Department alone, or by the Public Health Service alone. I think we have to sit down and address a revision of significance here to return to the good principles that you mention.

Home care in my opinion is excellent care. The mother who has taken care of nine children and raised them can provide things no one

else can provide in the right setting. But I think we have to come some way in the modern setting to try to work out the requirements that will allow the implementation of a common sense approach.

ELIMINATION OF POSITIONS

Mr. MICHEL. What were the 36 positions which you have eliminated, as the result of the Senate report language?

Dr. COOPER. In effecting the Senate reduction, we eliminated 36 positions previously allocated to 8 headquarters staff offices consisting of: 3 from the Office of Program Implementation, 17 from the Office of Administrative Management, 2 from the Office of International Health, 9 from the Office of Policy Development and Planning, 2 from the Office of Nursing Home Affairs, and 1 each from the Office of Public Affairs, Office of Health Legislation, and Office of Population Affairs.

TRANSFER OF POSITIONS

Mr. MICHEL. What about the 102 positions which have been transferred; what do they involve?

Dr. COOPER. The 102 positions transferred to the operating programs of the health agencies involve the transfer of functions that were previously administered by my staff offices. Specifically, the transfer consisted of 6 positions for report clearance, 61 positions for regional offices grants management functions, 18 positions for the Professional Standards Review Organization activities, 10 positions for End-Stage Renal Disease and 7 positions associated with Medical Care Standards.

DECENTRALIZED GRANT PROGRAMS

Mr. MICHEL. You refer to 6,000 grants worth $1.6 billion being awarded and administered in the regional offices. What agencies and programs do those grants fall under?

Dr. COOPER. The grants awarded and administered in the regional offices are in support of four of the six PHS agencies. Specifically, the agencies are the Alcohol, Drug Abuse, and Mental Health Administration, the Center for Disease Control, the Health Resources Administration, and the Health Services Administration. The various programs by agency are:

Alcohol, Drug Abuse, and Mental Health Administration: Health services development—project grants; hospital improvement grants; hospital staff development grants; community mental health centers; community mental health centers—construction; community mental health centers—staffing; alcohol formula grants; and child mental health services.

Center for disease control: Urban rat control; childhood lead-based paint poisoning control; disease control projects grants; and coal mine clinic grant program.

Health Resources Administration: Health service area grants; capital expenditure review—contracts; health facilities construction—grants and loan and loan guarantees; area health education centers; physicians assistants projects; operation MEDIHC projects; special health career opportunity projects; dental health continuing education projects; dental TEAM projects; grants for training in family

medicine; health professions construction grants; health professions loans and interest subsidies; health professions financial distress; health professions special project grants; grants for start-up assistance for school of medicine, osteopathy and dentistry; health professions capitation grants; health professions student loans; health professions scholarships; and, public health short-term training.

Health Services Administration: Comprehensive public health services—formula grants; crippled children services, maternal and child health services (formula and project); family health centers; migrant health grants; national health service corps; appalachian health demonstrations; emergency medical systems programs; emergency medical services systems training program; and, health maintenance organizations.

INDIRECT NEGOTIATED COST

Mr. MICHEL. Do the same regional offices negotiate the overhead or indirect cost rates?

Dr. COOPER. Yes; the offices of the regional comptroller in their respective regions are responsible for establishing departmentwide indirect cost rates for grants and contracts with all organizations other than profitmaking institutions.

Mr. MICHEL. Can you tell us what the average overhead rate is for each of the agencies under your jurisdiction which fund research?

Dr. COOPER. During fiscal year 1975 24.3 percent of the total research grant dollar was spent for indirect costs. Although precise overhead data is not readily available by agency, there are only minor differences between the six PHS operating components, which consist of Alcohol, Drug Abuse and Mental Health Administration, Center for Disease Control, Food and Drug Administration, Health Resources Administration, Health Services Administration, and National Institutes of Health.

RESEARCH PROGRAM

Mr. MICHEL. Can you also tell us what the total amount being spent for research is for all the agencies under your jurisdiction?

Dr. COOPER. A total of $2,510,756,000 is projected to be spent in fiscal year 1976 for research activities conducted by the six Public Health Service agencies.

Mr. MICHEL. Of the total for research, how much is actually going into overhead?

Dr. COOPER. As previously stated, approximately 24 percent of the research grant dollar is spent for indirect costs.

OVERHEAD COST FOR NONRESEARCH PROJECTS

Mr. MICHEL. Are there nonresearch grants and contracts awarded in your area (health) where overhead is paid? If so, in what areas, in what amounts, and in what overhead amounts?

Dr. COOPER. We estimate that approximately $2,229 million and $555 million were expended for nonresearch grants and contracts respectively in fiscal year 1975. There are two main types of nonresearch grants for which overhead is paid. The first is for training grants, where the indirect cost rate is approximately 8 percent. The

second is the health services program, where the indirect costs amount to approximately 1 percent.

I should point out that the 8 percent indirect cost rate for training grants results from a departmental restriction which limits reimbursement to the lesser of the institution's actual indirect cost rate or 8 percent. This was an administrative decision based on the fact that training awards generate different elements of indirect costs. This is due to the fact that the Government pays part of the instructors' salaries and other operating costs as direct charges to the training awards. Additionally, it is recognized by the Department and the educational community that these elements are costs which, of necessity, are incurred by instructional organizations with or without Government awards.

The 1 percent figure for health services grants is misleading when compared to the indirect costs paid under research grants. Institutions receiving health service grants typically, only have one grant and, therefore, according to Department and PHS policy, may charge all such costs as direct charges to the grant. Therefore many indirect-type costs are not reflected in the 1-percent figure.

There also are several programs which award overhead under nonresearch contracts. However, unlike nonprofit institutions in which the indirect cost rates are established by the Offices of the Regional Comptroller, indirect cost rates for commercial organizations are not established on a departmentwide basis. They are established by contracting officers through individual negotiations based on guidelines established by the Federal Procurement Regulations.

PROCEDURES FOR ESTABLISHING OVERHEAD RATES

Mr. MICHEL. Would you provide for the record a detailed description how overhead is established in your area, and the machinery for so establishing it. We got into this when Dr. Fredrickson was here, but that discussion left some doubts as to the extent to which overhead is determined on a departmentwide basis and the degree to which it is determined by each agency.

Dr. COOPER. We will provide the information.

[The information follows:]

As I stated previously, responsibility for reviewing and negotiating indirect costs for grants and contracts has been delegated to the Regional Comptroller in each of the 10 regional offices. Each Regional Comptroller is responsible for the determination of indirect cost rates for those institutions within the geographical boundaries of his region that receives Department grants and contracts.

Each institution claiming reimbursement for indirect costs must submit an indirect cost rate proposal to the applicable Regional Comptroller specifying how the rate was determined and computed in support of claims. Institutions receiving ongoing grants or contracts must submit this proposal annually. In addition, the Department publishes brochures describing the procedure and cost principles involved in the computation and approval of indirect cost rates. These publications are commonly referred to as "Office of the Assistant Secretary, Comptroller's Guides." There are guides for each of the various types of nonprofit organizations that the Department does business with, which consist of colleges, hospitals, State or local governments, and other nonprofit institutions.

The results of the indirect cost rate negotiation are formalized through a signed agreement with an appropriate regional official and an authorized representative of the institution. The negotiated agreement then sent to the Division of Financial Management Standards and Procedures, the Office of the Assistant Secretary, Comptroller, for publication and distribution to all operating components of the Department.

PEER REVIEW GUIDELINES

Mr. MICHEL. When you were here before, we talked about peer review, and you indicated that these peer review groups generally follow uniform, departmentwide guidelines in selecting grant recipients. Would you provide for the record a detailed description of these guidelines?

Dr. COOPER. As I indicated in last year's testimony before this committee, the application review practices varied considerably among PHS components. As a result, we have issued a policy which requires each agency and region to establish a formal system of grant application review which sets forth the review process to be followed by each program administered by that office. The basic purpose of these systems is to insure consistency, objectivity, and full documentation of one, the selection and appointment of the review persons; two, the results of the evaluation of applications; and three, final decisions made by the awarding officials. At least half of the members of all application review teams must be composed of persons from outside the awarding organization. Members of my immediate staff have reviewed the systems established by the various PHS awarding components and are satisfied that the objectives of our policy are being achieved. In addition, we conduct periodic onsite evaluations of the review activities of the various health components in order to assure that the policies are being carried out in actual practice.

MONITORING DECENTRALIZED PROGRAM

Mr. MICHEL. What kind of a monitoring system do the regional offices have for checking up on grants and insuring that the funds are being used for the intended purpose? Are independent audits required? Are site visits made in all cases?

Dr. COOPER. The monitoring processes used in the regional offices vary, depending upon the nature of the project, size of the grant, experience with the grantee institution, and the progress or lack thereof being made under the project. Project officers, who are assigned to each project, monitor grant activities through formal discussions by means of telephone and meetings and by analyses of progress and expenditure reports. From that point it is a matter of using judgment to determine what additional monitoring techniques are necessary. When the need is indicated, either site visits, audits conducted by commercial firms, or reviews by cognizant Government auditors are utilized.

PROGRAM DIRECTION AND SUPPORT SERVICES

Mr. MICHEL. Would you provide us with a breakdown of your "Program Direction" and "Support Services" allocation and personnel into the various subcategories to which they are allocated?

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Dr. COOPER. We would be happy to provide that for the record.
[The information follows:]

PROGRAM DIRECTION AND SUPPORT SERVICES

| | 1976 | | 1977 estimate | |
|---|---|---|---|---|
| | Positions | Amount | Positions | Amount |
| Immediate office | 32 | $1,061,000 | 32 | $1,099,000 |
| Office of Program Implementation | 44 | 1,259,000 | 44 | 1,300,000 |
| Office of Public Affairs | 9 | 325,000 | 9 | 337,000 |
| Office of International Health | 23 | 846,000 | 23 | 872,000 |
| Office of Health Legislation | 9 | 336,000 | 9 | 345,000 |
| Office of Equal Employment Opportunity | 9 | 267,000 | 9 | 278,000 |
| Office of Administrative Management: | | | | |
| Office of the Director | 16 | 554,000 | 16 | 572,000 |
| Office of Organization and Management Systems | 43 | 1,439,000 | 43 | 1,491,000 |
| Office of Personnel Management | 56 | 1,781,000 | 56 | 1,843,000 |
| Office of Resource Management | 112 | 3,666,000 | 112 | 3,799,000 |
| Office of Policy Development and Planning | 61 | 2,365,000 | 61 | 2,432,000 |
| Total | 414 | 13,899,000 | 414 | 14,368,000 |

SCIENTIFIC AND TECHNICAL COMMITTEES

Mr. MICHEL. Your justifications refer to 270 scientific and technical committees which your office has to manage. What generally are these committees and what is their purpose?

Dr. COOPER. The technical and scientific committees to which you refer is a committee system, commonly called the peer review system which is based on the premise that individuals best qualified to determine the merit of research proposals are those scientists most knowledgeable in the specialized fields in which the proposals fall.

The primary purpose of such committees is to assist us in achieving and maintaining the highest possible quality for our programs by obtaining expert advice on those research grant applications and contract proposals that offer the best hope of providing information which will improve the health and well-being, not only of the American people, but of populations in every part of the world. We must, therefore, rely on trained, experienced, and tested scientists for advice on such matters.

RESEARCH AND DEVELOPMENT

Mr. MICHEL. What kind of research and development is being conducted under your office?

Dr. COOPER. This office conducts no specific research and development projects from funds appropriated to the Assistant Secretary for Health appropriation. We do, however, have overall responsibility for the research activities conducted under the scientific activities overseas appropriation commonly referred to as Public Law 480 funds. All of the projects funded from Public Law 480 funds are carried out in designated excess foreign currency countries. Projects funded from Public Law 480 funds include: Basic biomedical research, cardiovascular diseases, cancer, infectious diseases, and the study of the fundamentals of life processes.

FORWARD PLAN FOR HEALTH

Mr. MICHEL. Would you briefly summarize for us the forward plan your office has developed for the coordination of health strategies?

Dr. COOPER. In our forward plan we have tried to set forth the major problems and issues confronting the health industry, and to respond to them by planning around seven themes: Prevention, knowledge development, improving the health care system, assuring the quality of health care, national health insurance, tracking and evaluation and management.

The plan has three purposes. First, it sets the context for developing our annual budget request which presents a comprehensive and coherent view of what we are doing or propose to do. It is centered around issues and themes rather than agencies which serve as the focal point for conveying to the Secretary, and to the Office of Management and Budget the rationale behind our requests for resources; second, it serves as a focal point for organizing a number of related activities such as legislative planning, operational planning, evaluation planning, and liaison with outside groups; and third, and perhaps the most important, it serves as a basis for establishing a mutual cooperative relationship between the health industry and Government.

We are optimistic that if enough of us who are concerned about health can define and aim at the same target, we can all get there in a way that respects both the culture and the diversity of interests that characterize America. It is our view, that the forward plan for health will contribute significantly toward constructive communications among all the parties who are concerned with our national health problems and/or goals.

INFORMED CONSENT FOR STERILIZATION

Mr. MICHEL. Where do you stand at present regarding the question of "Informed Consent for Sterilization?"

Dr. COOPER. On April 18, 1974, HEW published regulations in the Federal Register with respect to persons legally capable of giving informed consent to a sterilization while continuing in effect the moratorium on sterilization of those for whom informed consent is problematic due to age or mental capacity. These regulations outlined six essential elements of informed consent which must be covered and documented by a long or short written consent form. The regulations mandated a 72-hour waiting period between the signing of the consent form and the performance of the sterilization. In addition, the regulations required the following legend to be displayed prominently at the top of each consent document:

NOTICE

**Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects.**

Following publication of the April 18, 1974, regulations, the Department directed all regional offices to develop consent forms in compliance with the regulations. The Department also prepared and distributed model consent pamphlets for three types of sterilization procedures.

Surveillance of sterilizations subject to the August 3, 1973, moratorium and the April 18, 1974, regulations consists of two activities: reporting and auditing. Reporting monitors violations of the moratorium, and audit, the regulations and the moratorium.

CURRENT STATUS OF PHYSICAL FITNESS

Mr. MICHEL. Where do we presently stand as a Nation with respect to physical fitness? Are we doing better or are we sliding backwards?

Dr. COOPER. In the 20 years or so since the President's Council on Physical Fitness and Sports was established, America's fitness attitudes and practices have changed dramatically. Some of the changes include: One, routine prescribed exercise by physicians as a means of maintaining and enhancing health; two, America is in the midst of a genuine participant sports boom in that we are presently buying more bicycles than automobiles, and the number of skiers and tennis players has tripled; three, joggers, back-packers, and bicycle commuters are now commonplace in most communities; four, the number of young women participating in interscholastic and intercollegiate sports has quadrupled in the decade; and five, approximately 12 million boys and girls try out for the Presidential Physical Fitness Award each school year. It is, therefore, evident that tremendous gains are being made attitudinally, but large pockets of public apathy, urban growth and the modern lifestyle continually threaten to neutralize physical fitness advances. While much has been accomplished during the past 20-year history of the physical fitness program there is a long road ahead if we expect to reduce the impact of physical inactivity and the resulting degeneration which reflects on national morbidity and mortality rates, as well as financial costs to Government, industry, and individuals.

CURRENT STATUS OF PHYSICAL FITNESS

Mr. MICHEL. How do we compare with other nations as far as our physical fitness is concerned?

Dr. COOPER. There is no data comparing the physical fitness levels of individuals that is internationally recognized or agreed to between or among sovereign countries.

INTEREST IN PHYSICAL FITNESS

Mr. MICHEL. Is interest in physical fitness in our country increasing or decreasing? Are you having an easier or harder time than before in convincing people of this need?

Dr. COOPER. The interest in physical fitness in the United States is very high and continues to increase. The mass media has regularly featured presentations on physical fitness for the individual, executives, and employees. According to a national survey, 90 percent of the Americans questioned said that elementary and secondary schools should have physical education programs. Physicians are informing the public that future improvements in the level of health lie mainly in moderate self-imposed exercises.

We are having a much easier time in convincing people of this need but still find the average individual does not have the necessary self-

discipline to exercise regularly. Most Americans prefer good health to illness and a long life to a shorter one. We may well be on the road to changing that old axiom from, "the survival of the fittest," to the "survival of the exerciser."

INCREASE FOR RETIRED PAY AND MEDICAL BENEFITS

Mr. MICHEL. What accounts for the rather sharp increase of 16 percent in retirement pay and medical benefits for commissioned officers?

Dr. COOPER. The retirement pay increase is due in part to an increased number of retirees and survivors but in large part a result of the increased base pay on which retirement is calculated and the cost of living increases resulting from inflation.

Of the $3.4 million increase for medical care $2.4 million results from cost increases and $1 million from a projected increase in workload.

Mr. MICHEL. Since 1970, we have had over a 300 percent increase in this category. Why?

Dr. COOPER. The increase in the retired pay and medical benefits since 1970 is due to the larger number of retired officers and survivors (484) receiving retired pay and the numbers of beneficiary services provided under the medical care element. The largest portion of the increases are a result of cost of living increases in retired compensation and increased costs of providing medical care.

PHS HOSPITAL CLOSURE COSTS

Mr. MICHEL. When the Health Services Administration people were before us, we received an unclear answer to the question of whether eliminating the Public Health Service hospitals would save money. The response was that there would be relatively little savings in the short run, but the long run question wasn't addressed. Isn't it true that in the long run there would be some significant savings by contracting out the health care rather than operating hospitals to provide it?

Dr. COOPER. No; this is not the case. Our analysis of costs of operating Public Health Service hospitals as compared to the costs of providing that same care in community hospitals have consistently shown that provision of care in PHS operated hospitals costs less than in community hospitals. This applies both to the short run and to the long run. Dr. van Hoek indicated in his testimony that the cost to this appropriation for operating the PHS hospitals in 1977 would be about $127 million, and that would permit our continuing to care for all patients, as we currently do. If the hospitals are closed and we contract out for inpatient care for just our primary beneficiaries, the cost would be $112 million plus $11 million for the care of Coast Guard primary beneficiaries. So, there would be some savings if we make this kind of comparison. However, if the hospitals were closed and all of the current patients, primary and secondary beneficiaries, were to receive care in community facilities, there would be an additional cost to the Federal Government of $24 million, while non-Federal patient costs would increase by $7 million. In total then, the cost would be $31 million higher than the $127 million needed to operate the PHS hospitals.

SPECIAL FOREIGN CURRENCY PROGRAM UNOBLIGATED BALANCE

Mr. MICHEL. What accounts for the substantial reduction of unobligated funds for the special foreign currency program in fiscal year 1977 compared with the amount available at the start of fiscal year 1976.

Dr. COOPER. At the beginning of fiscal year 1976, $27,443,000, which had been appropriated for our use in previous years but not used for reasons unrelated to the quality of the program itself, was available under this account. Of this amount, $13,124,000 is planned for obligation during fiscal year 1976 and $2,012,000 during the transition quarter, leaving a balance of $12,307,000 in unobligated funds for use during fiscal year 1977. The reduction you speak about is due to the fact that we are using $13,124,000 of this unobligated money for program operations during fiscal year 1976 and $2,012,000 during the transition period. We did not request any new authority for this program in our fiscal year 1976 and transition quarter budgets, since this money was already available.

The $13,124,000 in new obligations during fiscal year 1976 will be for approximately 40 new projects and additional support for about 20 ongoing projects in Egypt, India, Pakistan, Poland, and Tunisia. The $2,012,000 will provide funds for about 10 projects during the transition quarter.

Mr. FLOOD. Mr. Conte.

ADMINISTRATION OF DECENTRALIZED PROGRAMS

Mr. CONTE. Dr. Cooper, last year I discussed with you the conflict between the administrative control of the regional office and the budgetary control of the agencies. You indicated that you were aware of the problem and that they would work themselves out. I still am getting reports of this nature. When will these problems get worked out?

Dr. COOPER. These problems are working themselves out through the Regional Health Administrator's work plan. The agencies provide the regional office with guidance, both programmatic and resources, and the regional offices submit their work plan for review and concurrence. Monthly financial reports are submitted to the agencies for their use in budgetary review of decentralized activities. In addition, there are quarterly meetings where the Regional Health Administrators and the agency heads discuss progress and/or problems related to program implementation.

NURSING HOME CARE SURVEY

Mr. CONTE. Last year, Dr. Abdellah gave us some previews of the nursing home inspection survey because the full report was not yet out. What did you learn from that report and how much has been implemented to correct this problem?

Dr. COOPER. The long-term care campaign for the improvement of nursing homes that was conducted in fiscal year 1975 included a fact-finding survey of nursing facilities. The survey was designed to answer three basic questions: Who are the patients, how are nursing homes managed, and how good is patient care? A complete report of the sur-

vey findings was published by the Department in July 1975, and contains specific findings about patient characteristics, facility management, and patient care. After studying the findings, we are now implementing a second long-term care facility campaign as our phase II effort, to evaluate patient care in nursing homes.

We believe that one direct way of improving patient care is to measure an individual patient's outcome systematically at regularly scheduled intervals. This would provide a method for determining the allocation of resources in a facility including manpower. Thus, services provided would be those actually needed and delivered to patients. This process is called a patient assessment survey. In addition, we propose to assess all of the present medicare and medicaid standards to identify those that relate to facility improvement and those that provide an evaluation of patient care, introduce consolidated survey/certification procedures into all 10 HEW regions and assess reimbursement mechanisms with a view toward developing reimbursement procedures with incentives linked to performance.

We anticipate that phase II will require 3 to 4 years for full implementation.

NURSING HOME CERTIFICATION SURVEY

Mr. CONTE. Have you reviewed the survey certification process for nursing homes?

Dr. COOPER. The survey certification process for nursing homes is continually reviewed to determine areas for improvement. As indicated earlier, one specific finding of the long-term care facility improvement study was that the survey certification process needs to be refocused to ascertain each patient's actual needs. Phase II of the long-term care improvement campaign will address this problem.

In addition, the Office of Nursing Home Affairs and Office of Long-Term Care Standards Enforcement in region IV have joined with several States within that region in a pilot project to test methods of reducing the amount of paperwork now required in the survey certification process.

REGIONAL OFFICES STAFF

Mr. CONTE. Under the regional management there are 6,000 grants worth $1.6 billion. How many people do you have overseeing the administration of these grants?

Dr. COOPER. Currently there are a total of 1,467 positions assigned to the regional offices. These positions are there for both the technical and programmatic functions associated with administering the grants programs and for conducting the total affairs of PHS's decentralized health efforts.

POPULATION AFFAIRS

Mr. CONTE. How much of the health care assurance budget goes to the Office of Population Affairs? What is its purpose and accomplishments?

Dr. COOPER. In fiscal year 1977, $285,000 of the health care assurance budget request for $1,521,000 is for the support of the Office of Population Affairs. This office was established in 1967 as a staff

office under the Assistant Secretary for Health to provide direction and coordination for family planning policies and programs and was continued by Public Law 91–572, the Family Planning Services and Population Research Act of 1970.

The Director of this Office advises the Secretary and me, on programs of national importance in the fields of population dynamics, fertility, sterility, and family planning and directs population and family planning activities throughout the Department.

As the focal point for all family planning services and population research activities in the Department, the Office has played a major role in resolving problems related to Government funded sterilizations and in resolving problems associated with the administration of the complex activities associated with family planning and population research.

The 1976, the Office prepared and submitted to Congress a 5-year plan and four progress reports on family planning services and population research programs. The reports indicate progress toward program goals, estimate the expected demand for subsidized family planning services and the funds available to provide the services, and provide information concerning the characteristics of patients served and indicates the various services provided by the program.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION BOARDS

Mr. CONTE. Have you reevaluated the policy on "Slotting" positions on PSRO boards? During our last discussion, Mr. Weinman indicated that he was aware of problems such as we had in western Massachusetts and would rethink the policy in this area.

Dr. COOPER. After program consideration of the comments by PSRO projects and consultation with DHEW legal counsel, the PSRO program policy was modified in October 1975, with regard to election of members of governing bodies and election of the permanent PSRO governing body. This revised policy will allow, within certain specified limits, reservation of governing body seats (1) for physicians in a geographic area and (2) for doctors of medicine and doctors of osteopathy as the two legislatively specified categories of physicians. This modification will simultaneously preserve the legislatively mandated right of each physician to be equally eligible for PSRO office and reasonably represented. In addition, PSRO's may continue to reserve positions for nonphysician members of the governing body.

MEDICAL MALPRACTICE

Mr. CONTE. What has your program direction and support services done in the medical malpractice area?

Dr. COOPER. It is the Department's view that where direct Government intervention is required in the malpractice problem, the appropriate level is the State because of their experience and authority in the areas of insurance regulation and licensure of health providers. Based on this policy, efforts in medical malpractice have been directed toward lending active assistance in the area of data collection, knowledge development and information dissemination. Specifically, in the area of data collection and knowledge development the Department,

through grants, contracts, and in-house studies is now in the process of obtaining data on the characteristics of malpractice claims and the injuries that lie behind the claims. Presently, we are studying the legal aspects, such as tort changes of the malpractice problem, examining the use of arbitration for malpractice claims, exploring alternative compensation systems, and studying the use of hospital injury prevention programs. Under the category of information dissemination the Department has a medical malpractice information center which provides data to the public and interested parties in the States' malpractice activities. In addition, members of the Department have addressed physicians, lawyers, insurance and State groups concerned with medical malpractice.

Mr. CONTE. Do you forsee any type of solution to the growing seriousness of the malpractice insurance problem?

Dr. COOPER. The first problem in malpractice has been the unavailability of insurance in certain areas of the country. Fortunately, solutions to the availability problem have been found. The solutions have taken a variety of forms—pooling of insurance companies into joint underwriting associations, special State insurance funds, provider owned self-insurance companies, and State reinsurance facilities.

The second problem of malpractice relates to the rapidly rising costs. This problem is more insidious and more difficult to deal with. Major efforts have been undertaken in this area also. Forty-nine States have had some activity addressed at the malpractice situation, either in the form of study commissions convened, bills introduced, or laws enacted. Already 32 States have enacted legislation aimed at the more difficult problem of malpractice costs. The proposals include changes in civil practice laws and rules, review panel, reporting and review of claims, and revisions in the powers of professional licensing agencies. During the next year I think we will continue to see activity on malpractice at the State legislatures.

The effectiveness of the measures being implemented is not yet known, and in fact, will not be known until we have gained some experience under these new laws. There have, however, been some indications from Indiana that their new law has been helpful.

Malpractice costs are a long-term problem that will require more time to solve than did the insurance availability issue. Some of the new measures being passed will undoubtedly be subjected to a court test. Because of the lack of claims experience under the new laws, and the potential that some of the laws may be overturned, the insurance companies feel that until more experience can be gained, good insurance practice mandates that the premiums not be lowered. Although everyone would like to see the premium rates go down immediately, we recognize that this is an unrealistic expectation.

In the interim, mechanisms such as the "claims made" policies and special State funds are being used to alleviate some of the burden of the high cost of malpractice occurrence insurance policies.

The malpractice problem varies across the States in its scope and intensity. There is still a lack of consensus for what types of alterations are required or effective. The current creativeness and variety of some of the State proposals provides a unique opportunity to evaluate the effectiveness of alterations in the current malpractice system.

INTERNATIONAL HEALTH INFORMATION

Mr. CONTE. How valuable is the health information collected by the Office of International Health? How is it dessimated?

Dr. COOPER. The Office of International Health has a continuing program of preparing "syncrisis studies" and conducting "health sector assessments." The syncrisis studies describe and analyze health conditions of a country and their interrelationships with and impact on socioeconomic development. Their purpose is to provide a concise, organized, and up-to-date introduction to the health situation in a country for use by HEW, the Agency for International Development, as well as by the international community as a whole. They have been valuable to us, AID and other organizations in planning health activities with other countries. These studies are provided to AID, the Department of State, other Government agencies, universities and foundations. The studies are also available for sale to the public through the Government Printing Office. We do know, by the way, that the syncrisis studies are used as tests in courses in several university schools of public health.

The health sector assessments, which are conducted in cooperation with the agency for International Development, are in-depth reviews and analyses of the needs, resources, and options available in health in selected lesser developed countries for the purpose of developing rational plans for allocation of available resources. In addition to being invaluable planning documents to AID, the assessments provide a unique opportunity for U.S. experts to gain knowledge which can be carried over to domestic problems. The assessment reports are provided to all concerned components of AID and country missions.

Additionally, the staff prepares background papers on selected countries which will better enable the Office to make informed policy and program recommendations and decisions regarding the initiation of new programs and coordination and administration of ongoing activities. Because these are informal documents developed for policy and administrative purposes, they are not disseminated to the public.

INFORMATION FLOW IMPROVEMENT

Mr. CONTE. How will the recommendation of the management information systems task force improve the flow of management information within the regional offices?

Dr. COOPER. The flow of information is a very complex problem and the management information systems task force is still pursuing its efforts to study the unnecessary, duplicative and often burdensome reporting systems laid on projects, as well as, the regional offices. Their recommendations are expected to improve information flow by eliminating outdated reporting systems related to various health resources and services programs by consolidating many of the categorical program information systems and requirements.

Mr. FLOOD. Thank you, doctor.

[The justifications follow:]

# JUSTIFICATION OF THE BUDGET ESTIMATES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH


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Appropriation Estimate

ASSISTANT SECRETARY FOR HEALTH

For expenses necessary for the Office of the Assistant Secretary for Health, [$20,842,000] *$22,216,000.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

Amounts Available for Obligation

| | 1976 Appropriation | 1977 |
|---|---|---|
| Appropriation | $20,842,000 | $22,216,000 |
| Proposed supplemental | 666,000 | --- |
| Subtotal, adjusted appropriation | 21,508,000 | 22,216,000 |
| Comparative transfer from: | | |
| "General Departmental Management" for administrative support of nationwide long-term care enforcement standards | 110,000 | --- |
| Subtotal, budget authority | 21,618,000 | 22,216,000 |
| Total, obligations | 21,618,000 | 22,216,000 |

Summary of Changes

| | |
|---|---|
| 1976 Estimated obligations | $21,618,000 |
| 1977 Estimated obligations | 22,216,000 |
| Net change | +598,000 |

| | 1976 Base Pos. | 1976 Base Amount | Change from Base Pos. | Change from Base Amount |
|---|---|---|---|---|
| Increases: | | | | |
| Built-in: | | | | |
| 1. Within grade increases | --- | $259,000 | --- | $249,000 |
| 2. Annualization of October 1975 pay raise costs | --- | 666,000 | --- | 223,000 |
| 3. FTS and telephone rate increases | --- | 152,000 | --- | 6,000 |
| 4. Increase in postage rates | --- | 66,000 | --- | 18,000 |
| 5, Standard Level User Charge | --- | 1,377,000 | --- | 82,000 |
| 6. PHS Service and Supply Fund costs | --- | 1,101,000 | --- | 78,000 |
| Subtotal | | | | 656,000 |
| Decreases: | | | | |
| Built-in: | | | | |
| One less day of pay | | | | -58,000 |
| Total, net change | | | | 598,000 |

Obligations by Activity

| Page Ref. | | 1976 Appropriation Pos. | 1976 Appropriation Amount | 1977 Estimate Pos. | 1977 Estimate Amount | Increase or Decrease Pos. | Increase or Decrease Amount |
|---|---|---|---|---|---|---|---|
| 204 | Regional Management.. | 160 | $5,197,000 | 160 | $5,266,000 | --- | +$69,000 |
| 205 | Program Direction and Support Services... | 414 | 12,958,000 | 414 | 13,371,000 | --- | +413,000 |
| 207 | Health Care Assurance | 47 | 1,495,000 | 47 | 1,521,000 | --- | +26,000 |
| 209 | President's Council on Physical Fitness and Sports..... | 12 | 591,000 | 12 | 599,000 | --- | +8,000 |
| | Standard Level User Charge..... | --- | 1,377,000 | --- | 1,459,000 | --- | +82,000 |
| | Total obligations. | 633 | 21,618,000 | 633 | 22,216,000 | --- | +598,000 |

Obligations by Object

| | 1976 Appropriation | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Total number of permanent positions.... | 633 | 633 | --- |
| Full-time equivalent of all other positions..... | 57 | 57 | --- |
| Average number of all employees..... | 671 | 671 | --- |
| Personnel compensation: | | | |
| Permanent positions..... | $13,680,000 | $14,022,000 | +$342,000 |
| Positions other than permanent..... | 867,000 | 877,000 | +10,000 |
| Other personnel compensation..... | 208,000 | 210,000 | +2,000 |
| Subtotal, personnel compensation | 14,755,000 | 15,109,000 | +354,000 |
| Personnel benefits..... | 1,588,000 | 1,622,000 | +34,000 |
| Travel and transportation of persons. | 971,000 | 971,000 | --- |
| Transportation of things..... | 30,000 | 30,000 | --- |
| Rent, communications, and utilities.. | 2,045,000 | 2,151,000 | +106,000 |
| Printing and reproduction..... | 185,000 | 185,000 | --- |
| Other services..... | 1,776,000 | 1,880,000 | +104,000 |
| Supplies and materials..... | 169,000 | 169,000 | --- |
| Equipment..... | 99,000 | 99,000 | --- |
| Total obligations by object..... | 21,618,000 | 22,216,000 | +598,000 |

Significant Items in House and Senate
Appropriations Committee Reports

| Item | Action taken or to be taken |
| --- | --- |
| 1976 Senate Report | |
| Assistant Secretary for Health | |
| The Committee reduced the budget request by $2,446,000 and recommended that a portion of the positions in this account be transferred to the various health services, research, regional and preventive programs (page 77). | To achieve this objective, the Office of the Assistant Secretary for Health eliminated 36 positions and transferred an additional 102 positions to be integrated directly with program operations in the various PHS agencies. The transfer of these 102 positions necessitates that the program activities receiving these positions absorb the costs of the staff within their appropriation and will in some cases require the reprogramming of program funds in order to support these transfers. |

Assistant Secretary for Health

| Year | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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... | 23,209,000 | 23,089,000 | 22,025,000 | 22,025,000 |
| 1976... | 23,288,000 | 23,142,000 | 20,842,000 | 20,842,000* |
| 1977... | 22,216,000 | | | |

* Conference agreement.

Assistant Secretary for Health

| | 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|---|
| | Pos. | Amount | Pos. | Amount | Pos. | Amount |
| Activities | | | | | | |
| 1. Regional Management.. | 160 | $5,633,000 | 160 | $5,728,000 | --- | +$95,000 |
| 2. Program Direction and Support Services... | 414 | 13,899,000 | 414 | 14,368,000 | --- | +469,000 |
| 3. Health Care Assurance | 47 | 1,495,000 | 47 | 1,521,000 | --- | +26,000 |
| 4. President's Council on Physical Fitness and Sports..... | 12 | 591,000 | 12 | 599,000 | --- | +8,000 |
| Total..... | 633 | 21,618,000 | 633 | 22,216,000 | --- | +598,000 |

General Statement

This appropriation provides support for the administrative staff required to administer the PHS health programs in the regional offices, staff for the Assistant Secretary for Health, staff for the coordination of the overall National efforts to assure the quality of the 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 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.

During 1976, due to congressional reductions from the budget request, the Office of the Assistant Secretary for Health eliminated 36 budgeted positions and transferred an additional 102 positions to the Public Health Service agencies. In addition, 11 positions were transferred from this account to the PHS Service and Supply Fund so as to more accurately relate direct service functions with operational activities of the various health agencies. Thirteen positions were transferred into this appropriation from the PHS Service and Supply Fund as a result of decentralization of personnel operations and 4 positions were transferred from the General Departmental Management appropriation in support of the nationwide long-term care enforcement standards efforts.

Regional Management

| 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|
| Pos. | Amount | Pos. | Amount | Pos. | Amount |
| 160 | $5,633,000 | 160 | $5,728,000 | --- | +$95,000 |

The staff supported by this activity is located in the ten PHS regional offices and in the PHS Office of Regional Operations. The regional staff supports the immediate office of the Regional Health Administrators, the principal Federal health representatives in the regions, who are responsible to the Assistant Secretary for Health. The staff of the Office of Regional Operations, located in headquarters, acts as an advisor to the Assistant Secretary for Health on 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.

During 1976, due to congressional reductions from the budget request, the grants management function consisting of 61 positions was transferred to three of the health agencies directly involved with the operations of the grants program and 9 additional positions were eliminated.

In 1976, the Regional Management staff continued to provide the overall management capabilities necessary for the administration of health programs in the ten regional offices. The main emphasis was on improving the Regional Health Administrator's Work Program system so as to more effectively carry out operational responsibilities in the regions. In addition, strong emphasis continued to be placed on improving coordination between the regional offices and State and local health agencies, improving management support activities, providing technical assistance in the area of grants and contracts administration and in implementing a manpower management program to cover 100% of regional activities.

In 1977, the regional offices will implement expected recommendations of the Management Information Systems task force to improve flow of management information within the regional offices and initiate steps to validate data in the regional Manpower Management program.

A net increase of $95,000 is required to provide for mandatory costs as follows:

| | | |
|---|---|---|
| 1. | Within grade increases effective during the year..... | +$34,000 |
| 2. | Annualization of the October 1975 pay raise..... | +49,000 |
| 3. | Standard Level User Charges..... | +26,000 |
| 4. | One less day of pay..... | -14,000 |
| | Total net change..... | +95,000 |

Program Direction and Support Services

| 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|
| Pos. | Amount | Pos. | Amount | Pos. | Amount |
| 414 | $13,899,000 | 414 | $14,368,000 | --- | +$469,000 |

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.

During 1976, due to congressional reductions from the budget request, 17 positions were transferred from this activity to the Public Health Service agencies and 24 positions were eliminated. Additionally, 11 positions were transferred to the PHS Service and Supply Fund in an effort to more accurately relate direct service functions to operational activities of the health agencies. As a result of the decentralization of personnel operations, 13 positions were transferred into this activity from the PHS Service and Supply Fund.

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 program implementation function proved effective in development and implementation of health planning legislation, administering the National Environmental Policy Act to improve coordination of programs involving toxic substances, directing committee management functions, coordinating patent appeals, and assisting in the resolution of health issues crossing agency lines. This function will continue in 1977 to aid the implementation, regulation and management of existing and new program policies. In addition, a manual will be developed and issued to assist in the management and control of the Public Health Service's over 270 scientific and technical committees.

During 1976, 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

strengthening of domestic health programs by making use of knowledge provided by international health organizations and foreign Ministries of Health, as well as knowledge gained through development of programs overseas as pilots for health programs in this country. New initiatives will involve the evaluation of ongoing bilateral programs so that decisions can be made to maintain or expand those of mutual benefit to the United States and other countries and to reduce or eliminate those which appear to be of limited value.

In the area of grants administration, a PHS grants policy manual was issued for use by applicant and grantee organizations which summarizes all PHS grant policies. An audit management system was developed to insure that all audit issues are promptly resolved and that the recommendations cited are effectively implemented. A plan was developed to assure competency at the regional office level to conduct self-evaluation of personnel management functions and to promote expanded participation of regional personnel officers in management's decision-making process involving human resources. Leadership was provided to the implementation and maintenance of a PHS-wide manpower management program.

The Forward Plan through 1981 was prepared coordinating health strategies in the areas of health data, health care, health improvement, health research, health protection, and health care financing. Other accomplishments included staff support to the medical malpractice effort and coordination of programs and policies which address the issues of resources, productivity and credentialing of health personnel, and health planning. These efforts will be continued in 1977 with particular emphasis on coordinating research plans for experiments and demonstrations related to changes in reimbursement methods and benefit changes aimed at reducing the cost of health care without adversely affecting the quality of care provided under the Social Security Act and completing the analyses of long-term care and ambulatory surgery projects.

In summary, a total of $14,368,000 is requested for the continuation of this activity at the 1976 level. The net increase of $469,000 over the 1976 operating level of $13,899,000 represents mandatory costs as follows:

| | | |
|---|---|---|
| 1. | Within grade increases | +$195,000 |
| 2. | Annualization of the October 1975 pay raise | +156,000 |
| 3. | Standard Level User Charge | +56,000 |
| 4. | Payments to PHS Service and Supply Fund | +78,000 |
| 5. | FTS and telephone rate increases | +6,000 |
| 6. | Increase in postage rates | +18,000 |
| 7. | Less one day of pay | -40,000 |
| | Total net change | +469,000 |

Health Care Assurance

| 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|
| Pos. | Amount | Pos. | Amount | Pos. | Amount |
| 47 | $1,495,000 | 47 | $1,521,000 | --- | +$26,000 |

The staff supported by this activity provides technical advice on programs of health care standards and quality assurance matters as well as a range of other matters pertaining to quality standards.

During 1976, 24 positions were transferred to the health agencies and 3 eliminated due to congressional reductions from the budget request. Four positions were transferred from the General Departmental Management appropriation in support of the nationwide long-term care enforcement standards effort.

This activity includes staff and related costs for the Offices of Quality Standards, Nursing Home Affairs, and Population Affairs.

Some of the achievements and objectives for 1976 and 1977 are:

The newly created Office of Quality Standards will coordinate for the Assistant Secretary activities regarding Professional Standards Review Organizations, Utilization Review, quality assurance aspects of the Health Maintenance Organizations, and the End-Stage Renal Disease programs.

The Office of Nursing Home Affairs, as an outgrowth of the Long-Term Care Study, will disseminate in 1976 publications on assessing health care needs in skilled nursing facilities, physicians' drug prescribing patterns, and a consumers' guide on selecting a nursing home. Also published was the Introductory Report of the Long-Term Care Facilities Improvement Campaign. In 1976, trial development of tools to objectively measure the quality of nursing homes will be completed, leading to establishment in 1977 of criteria to ensure uniform national inspection and rating of nursing homes.

In 1976, the Office of Population Affairs worked toward the resolution of issues related to informed consent for sterilization, especially those related to individuals who by reason of age or other factors are not considered competent to provide informed consent. Work continued with the Bureau of Community Health Services/PHS, and the Social and Rehabilitation Service regarding the effects of new

social service legislation as it related to family planning services under Title XX of the Social Security Act. In 1977, the Office of Population Affairs will continue its regular program of staff assistance to the Assistant Secretary for Health and the Secretary and its program direction activities with the Bureau of Community Health Service and the Center for Population Research. Staff studies related to national health insurance will be an area of emphasis.

In summary, a total of $1,521,000 is required for the continuation of this activity. The net increase of $26,000 over the 1976 operating level of $1,495,000 represents mandatory costs as follows:

| | |
|---|---|
| 1. Within grade increases..... | +$16,000 |
| 2. Annualization of the October 1975 pay raise..... | +14,000 |
| 3. Less one day of pay..... | -4,000 |
| Total net increase..... | +26,000 |

President's Council on Physical Fitness and Sports

| 1976 Appropriation | | 1977 Estimate | | Increase or Decrease | |
|---|---|---|---|---|---|
| Pos. | Amount | Pos. | Amount | Pos. | Amount |
| 12 | $591,000 | 12 | $599,000 | --- | +$8,000 |

This activity supports staff and related costs for the continuation and furtherance of the National Physical Fitness and Sports Program; places major emphasis in the areas of promoting private support for physical fitness and mass amateur sports development; conducts continuing public service information programs about the nature and extent of the Nation's physical fitness problem; provides technical service to Federal, State and local agencies, and education, recreation, and sports and physical fitness associations; conducts a number of National incentive programs; and sponsors regional and State inservice training clinics for physicians, physical educators and other professionals.

During 1976 the Council's motivational and incentive programs for youth, adults, and physical education leaders were expanded. Leadership training was provided through: (1) regional clinics on physical fitness and sports for over 10,000 physical fitness and physical education leaders; (2) workshops on physical fitness for the elderly for over 1,600 participants; and (3) medical symposiums on exercise and health for 1,500 physicians and physical educators. A Fire Fighter's Fitness program with resource materials and films was developed and implemented for fire fighters. A followup on the 1972 National Adult Fitness survey updated the status of exercise and physical activity habits of adults. The number of governors' councils on physical fitness increased. Evaluation of the National Youth Physical Fitness test was completed and new norms developed. The private sector continued to support a number of physical fitness programs developed by the Council.

Plans for 1977 will involve: (1) a special effort to enlist the active support and assistance of city officials in developing and implementing mass physical fitness programs in community recreation departments; (2) assisting business, industry, government, and labor organizations in the establishment of sound physical fitness programs designed to elevate employees' health and reduce health-care costs resulting from physical inactivity; and (3) conducting educational programs for the general public on the importance of exercise and the value of regular physical activity for improved health. In addition, the Council's award program will be expanded to include a Master of Fitness Award for adults.

A mandatory increase of $8,000 is requested to provide for within grade costs, $4,000; and annualization of the October 1975 pay raise, $4,000.

ASSISTANT SECRETARY FOR HEALTH

Program Purpose and Accomplishments

Activity: Regional Management

| 1976 | | | 1977 | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 160 | $5,633,000 | Indefinite | 160 | $5,728,000 |

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 determining 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 1976: In 1976, the emphasis was on improving the Regional Health Administrator's Work Program system so that the regional offices would be in a position to more effectively carry out operational responsibilities in the regions. Analysis was made of the flow of management information in the regional offices.

Objectives in 1977: The regional offices will implement recommendations of the Management Information Systems task force to improve the flow of management information within the regional offices and initiate steps to validate data in the regional Manpower Management program.

ASSISTANT SECRETARY FOR HEALTH

Program Purpose and Accomplishments

Activity: Program Direction and Support Services

| 1976 | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 414 | $13,899,000 | Indefinite | 414 | $14,368,000 |

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 1976: In 1976, the Forward Plan for Health was prepared and accomplishments were made in the development of comprehensive health insurance proposals and other health policies and needs. Major gains continued to be made in the integration of the Public Health Service's international activities and domestic programs as well as the coordination of policy and health functions among the health agencies.

Objectives for 1977: Management control of scientific and technical committees will be improved. More domestic benefit will be derived from bilateral health programs.

ASSISTANT SECRETARY FOR HEALTH

Program Purpose and Accomplishments

Activity: Health Care Assurance

| 1976 | | 1977 | | |
|---|---|---|---|---|
| | | | | Budget Estimate |
| Pos. | Amount | Authorization | Pos. | Amount |
| 47 | $1,495,000 | Indefinite | 47 | $1,521,000 |

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 Quality Standards, Nursing Home Affairs, and Population Affairs.

Accomplishments in 1976: 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. Uniform inspections and ratings for nursing homes were developed and tested for grading nursing home care. Some 4 million women received subsidized family planning services through organized programs.

Objectives in 1977: There will be continued efforts to improve nursing home care and facilities along with making home health a viable alternative to the spiraling health care costs. National health insurance's impact on delivery of family planning services will be assessed.

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ASSISTANT SECRETARY FOR HEALTH

Program Purpose and Accomplishments

Activity: President's Council on Physical Fitness and Sports

| 1976 | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| 12 | $591,000 | Indefinite | 12 | $599,000 |

Purpose: This activity supports a national program of encouraging greater emphasis in the areas of physical fitness and sports.

Explanation: To provide funding for the President's Council on Physical Fitness and Sports and the supporting staff.

Accomplishments in 1976: In 1976, the Presidential awards program was expanded; the number of governors' councils on physical fitness increased; regional clinics, workshops, and symposiums were held with physicians, physical educators, and the elderly; and a fire fighters fitness program was developed and implemented.

Objectives for 1977: Special efforts will be exerted to assist public and private agencies and organizations in developing and implementing physical fitness programs as a basis for the improvement of health which will result in a reduction in financial costs and an increase in the quality of human life.

Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Estimate | Transition Quarter |
| 1. Regional Management | $5,197,000 | $1,316,000 |
| Standard Level User Charge | 436,000 | 109,000 |
| 2. Program Direction and Support Services | 12,958,000 | 3,299,000 |
| Standard Level User Charge | 941,000 | 235,000 |
| 3. Health Care Assurance | 1,495,000 | 377,000 |
| 4. President's Council on Physical Fitness and Sports | 591,000 | 149,000 |
| Total | 21,618,000 | 5,485,000 |

Explanation

Funds are required for the transition quarter to permit continuation of the 1976 operating level during this interim period.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

F.Y. 1977 Budget


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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; 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.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Amounts Available for Obligation

| | 1976 | 1977 |
|---|---|---|
| Appropriation (Indefinite)..... | $45,013,000 | $52,352,000 |

Summary of Changes

| | |
|---|---|
| 1976 Estimated Obligations | $45,013,000 |
| 1977 Estimated Obligations | 52,352,000 |
| Net change | 7,339,000 |

| | 1976 Base Amount | Change from Base Amount |
|---|---|---|
| Increases: | | |
| A. Built-in: | | |
| 1. Annualization of retirements during 1976 and the transition quarter and 89 additional retirements during 1977 | $23,067,000 | +$3,781,000 |
| 2. Net increase of 15 survivors receiving benefits | 600,000 | +117,000 |
| 3. Cost of increased inpatient and outpatient care for retirees and dependents | 19,894,000 | +3,236,000 |
| 4. Increase for ancillary services (drugs, handicapped care, contractors' fees, etc.) required by an expanding beneficiary population | 1,452,000 | +205,000 |
| Total increases | | +7,339,000 |

Obligations by Activity

| Page Ref. | | 1976 Appropriation Amount | 1977 Estimate Amount | Increase or Decrease Amount |
|---|---|---|---|---|
| 223 | Retirement payments..... | $23,067,000 | $26,848,000 | +$3,781,000 |
| 224 | Survivors' benefits..... | 600,000 | 717,000 | +117,000 |
| 225 | Dependents' medical care..... | 21,346,000 | 24,787,000 | +3,441,000 |
| | Total obligations..... | 45,013,000 | 52,352,000 | +7,339,000 |

Obligations by Object

| | 1976 Appropriation Amount | 1977 Estimate Amount | Increase or Decrease Amount |
|---|---|---|---|
| Benefits for former personnel.... | $23,667,000 | $27,565,000 | +$3,898,000 |
| Other services..... | 21,346,000 | 24,787,000 | +3,441,000 |
| Total obligations by object.... | 45,013,000 | 52,352,000 | +7,339,000 |

Retirement Pay and Medical Benefits
for Commissioned Officers

| Year | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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 | 39,499,000 |
| 1976 | 45,013,000 | 45,013,000 | 45,013,000 | |
| 1977 | 52,352,000 | | | |

1977 Congressional Justification

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

| | 1976 Appropriation Amount | 1977 Estimate Amount | Increase or Decrease Amount |
|---|---|---|---|
| Retirement payments..... | $23,067,000 | $26,848,000 | $3,781,000 |
| Survivors' benefits..... | 600,000 | 717,000 | 117,000 |
| Dependents' medical care..... | 21,346,000 | 24,787,000 | 3,441,000 |
| Total obligations..... | 45,013,000 | 52,352,000 | 7,339,000 |

General Statement

This appropriation provides for retirement payments to Public Health Service officers who are retired for age, disability, or length of service as well as payments to survivors of deceased retired officers who had received reduced retirement payments.

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.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Retirement Payments

| | 1976 Appropriation Amount | 1977 Estimate Amount | Increase or Decrease Amount |
|---|---|---|---|
| Other expenses..... | $23,067,000 | $26,848,000 | $3,781,000 |

This estimate provides for mandatory payments for officers retired for age, length of service, or disability.

Impact of the 1977 Budget:

- The estimate is based on payments to the following number of retirees:

| Period Ending | Total |
|---|---|
| June 30, 1975 | 1,375 |
| June 30, 1976 | 1,458 |
| Sept. 30, 1976 | 1,479 |
| Sept. 30, 1977 | 1,568 |

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Survivors' Benefits

| | 1976 Appropriation Amount | 1977 Estimate Amount | Increase or Decrease Amount |
|---|---|---|---|
| Other expenses..... | $600,000 | $717,000 | $117,000 |

This activity provides for the payment of annuities to survivors of retired officers who elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

Impact of 1977 Budget:

- The estimate is based on payments to the following numbers of annuitants.

| Period Ending | Total |
|---|---|
| June 30, 1975 | 112 |
| June 30, 1976 (Est.) | 124 |
| Sept. 30, 1976 (Est.) | 128 |
| Sept. 30, 1977 (Est.) | 139 |

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Dependents' Medical Care

| | 1976 Appropriation Amount | 1977 Estimate Amount | Increase or Decrease Amount |
|---|---|---|---|
| Other expenses..... | $21,346,000 | $24,787,000 | $3,441,000 |

This program provides for the cost of medical care rendered 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.

Impact of 1977 Budget:

- The estimate is based upon the following workloads:

| Period | Average Daily Patient Load | Outpatient Claims | Handicapped Care Recipients |
|---|---|---|---|
| 1975 | 326 | 26,000 | 175 |
| 1976 (Est.) | 335 | 26,900 | 175 |
| Transition Quarter (Est.) | 352 | 8,700 | 178 |
| 1977 (Est.) | 352 | 27,900 | 184 |

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)

| 1976 Appropriation Amount | 1977 Authorization | 1977 Budget Estimate Amount |
|---|---|---|
| $23,067,000 | Indefinite | $26,848,000 |

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: An estimated 83 retirees in 1976 and 21 retirees in the Transition Quarter will be added to the retirement roll, resulting in a total of 1,458 retirees as of June 30, 1976 and 1,479 as of September 30, 1976.

Objective for 1977: A net increase of 89 officers will result in an estimated total of 1,568 retired officers at the end of fiscal year 1977.

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)

| 1976 Appropriation Amount | 1977 Authorization | 1977 Budget Estimate Amount |
|---|---|---|
| $600,000 | Indefinite | $717,000 |

Purpose: Under the provisions of the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan, retired personnel who elect to receive reduced amounts of retirement 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: It is estimated that there will be a total of 124 annuitants as of June 30, 1976 and 128 by September 30, 1976.

Objectives for 1977: It is estimated that there will be a total of 139 annuitants on the rolls at the end of fiscal year 1977.

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)

| 1976 Appropriation Amount | 1977 Authorization | 1977 Budget Estimate Amount |
|---|---|---|
| $21,346,000 | Indefinite | $24,787,000 |

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 retired person 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 the 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: It is estimated that in 1976 a daily average of 335 persons will be hospitalized, 26,900 total outpatient claims will be processed and 175 beneficiaries will receive care under the handicapped care provision of the Dependents' Medical Care Act. The workload for the Transition Quarter is estimated to be 3% greater than the same three months in 1976.

Objectives in 1977: The estimated number of eligible beneficiaries in 1977 will be 3.6% greater than that of 1976. The level of funding requested will allow delivery of health care to this larger beneficiary population. Currently, there are anticipated in non-Public Health Service facilities an average daily inpatient load of 352, total outpatient claims of 27,900 and 184 handicapped care cases.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officer

Transition Quarter Analysis

| | Budget Authority by Activity | |
|---|---|---|
| | 1976 Appropriation | Transition Quarter |
| 1. Retirement Pay | $23,067,000 | $7,019,000 |
| 2. Survivors' Benefits | 600,000 | 149,000 |
| 3. Dependents' Medical Care | 21,346,000 | 6,384,000 |
| Total | 45,013,000 | 13,552,000 |

Explanation

Funds are required for the transition quarter to provide for the mandatory obligations of this program of the Public Health Service. These obligations include the annualization of 1976 retirements and annuities plus 21 additional retirees and 4 additional annuitants expected to come on the rolls as well as three months non-Public Health Service medical care costs for the estimated beneficiary population of 166,800.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Scientific Activities Overseas (Special Foreign Currency Program)

FY 1977 Budget


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Appropriation Estimate

*SCIENTIFIC ACTIVITIES OVERSEAS (SPECIAL FOREIGN CURRENCY PROGRAM)*

*For payments in foreign currencies which the Treasury Department determines to be excess to the normal requirements of the United States, for necessary expenses for conducting scientific activities overseas, as authorized by law, $1,500,000 to remain available until expended: Provided, That this appropriation shall be available in addition to other appropriations for such activities, for payments in the foregoing currencies.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Scientific Activities Overseas (Special Foreign Currency Program)

Amounts Available for Obligation

| | 1976 Estimate | 1977 Estimate |
|---|---|---|
| Appropriation | --- | $1,500,000 |
| Unobligated balance, start of period | $27,443,000 | 12,307,000* |
| Unobligated balance, end of period | -14,319,000* | --- |
| Total, obligations | 13,124,000 | 13,807,000 |

*The difference of $2,012,000 between the unobligated balance at the end of 1976 and the unobligated balance at the start of 1977 represents estimated obligations for the transition quarter.

Summary of Changes

| | |
|---|---|
| 1976 Estimated Obligations | $13,124,000 |
| 1977 Estimated Obligations | 13,807,000 |
| Net change | +683,000 |

| | Base | Change from Base |
|---|---|---|
| Program Increases: | | |
| 1. Disease Prevention Research | $3,125,000 | +$246,000 |
| 2. Health Services Research | 1,011,000 | +142,000 |
| 3. Biomedical Research and Health Science Communication | 3,808,000 | +646,000 |
| Total, increases | | +1,034,000 |
| Program Decreases: | | |
| 1. Alcohol, Drug Abuse and Mental Health Research | 825,000 | -88,000 |
| 2. Food and Drug Research | 1,280,000 | -208,000 |
| 3. Health Resources Research | 3,075,000 | -55,000 |
| Total, decreases | | -351,000 |
| Total, net change | | +683,000 |

Explanation of Changes

The $683,000 increase is the net change resulting from changes in program emphasis on specific health problems and the anticipated increase in the program in India and Poland.

Program Increase:

1. Center for Disease Control - The net increase of $246,000 will be directed toward studies to prevent and control infectious diseases

2. Health Services Administration - The net increase of $142,000 will be directed toward a program for studies aimed at improving delivery of rural health services.

3. National Institutes of Health - The net increase of $646,000 will permit a program increase of $543,000 for basic biomedical research, $53,000 for population and family planning studies and $50,000 for nutrition research.

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Program Decreases:

1. Alcohol, Drug Abuse and Mental Health Administration - The decrease of $88,000 represents a decrease in a number of projects funded in F.Y. 1977 in the field of alcoholism.

2. Food and Drug Administration - The net decrease of $208,000 represents the reduction in planned drug research.

3. Health Resources Administration - The net decrease of $55,000 represents a reduction in new obligations for studies directed toward improving the organization and delivery of health services.

Obligations by Activity

| Page Ref. | | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|---|
| 238 | Foreign health research | $13,124,000 | $13,807,000 | +$683,000 |

Obligations by Object

| | 1976 Estimate | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Travel and transportation of persons | $196,000 | $210,000 | +$14,000 |
| Other services: | | | |
| Project contracts | 12,928,000 | 13,597,000 | +669,000 |
| Total obligations | 13,124,000 | 13,807,000 | +$683,000 |

Authorizing Legislation

| Legislation | Amount Authorized | 1977 Budget Request |
|---|---|---|
| Agricultural Trade Development and Assistance Act of 1954, as amended, Section 104(b) | Indefinite | None |
| International Health Research Act of 1960, Section 3 | Indefinite | $1,500,000 |

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Scientific Activities Overseas (Special Foreign Currency Program)

| Year | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 1967 | $19,217,000 | $19,217,000 | $10,000,000 | $10,000,000 |
| 1968 | 18,685,000 | 15,000,000 | 15,000,000 | 15,000,000 |
| 1969 | 30,000,000 | 15,000,000 | 15,000,000 | 15,000,000 |
| 1970 | 3,455,000 | 3,455,000 | 3,455,000 | 3,455,000 |
| 1971 | 32,444,000 | 32,444,000 | 32,444,000 | 32,444,000 |
| 1972 | 25,545,000 | 25,545,000 | 25,545,000 | 25,545,000 |
| 1973 | 25,619,000 | 25,619,000 | 25,619,000 | 25,619,000 |
| 1974 | 1,912,000 | 1,912,000 | 1,912,000 | 1,912,000 |
| 1975 | --- | --- | --- | --- * |
| 1976 | --- | --- | --- | --- * |
| 1977 | 1,500,000 | | | |

*No new budget authority was requested in 1975 and 1976 due to the availability of prior years unobligated appropriation balances.

Scientific Activities Overseas (Special Foreign Currency Program)

| | 1976 Base | 1977 Estimate | Increase or Decrease |
|---|---|---|---|
| Foreign Health Research.... | $13,124,000 | $13,807,000 | +$683,000 |

General Statement

The Scientific Activities Overseas (Special Foreign Currency Program) is carried out under the authorities provided by Section 104(b) of Public Law 83-480, the Agricultural Trade Development and Assistance Act of 1954, as amended; and, Section 3 of Public Law 86-610, the International Health Research Act of 1960, as amended. Funding under this appropriation is entirely with U.S.-owned "excess" foreign currencies which were generated through the sale of surplus U.S. agricultural commodities and repayments on Mutual Security Loans. In 1977, it is anticipated that currencies will be available for use by the health agencies in the Arab Republic of Egypt, Burma, Guinea, India, Pakistan, Poland and Tunisia. These "excess currency" countries are designated by the U.S. Treasury Department using the criteria that the supply of U.S.-owned currency in the country must be sufficient to finance normal U.S. needs for at least two years.

Responsibility for the overall management and coordination of the Program is vested in the Office of International Health, a staff office to the Assistant Secretary for Health. The money made available through this appropriation is used by the six health agencies to finance cooperative health research projects, training, symposiums and conferences, translations of health science literature, and related activities in the participating foreign countries.

Since the Program's inception in 1962, more than 400 research projects and related activities have been funded in eleven countries. All of the research projects are collaborative in nature and are designed to benefit the United States as well as the host country. Projects are reviewed by the government of the foreign country as well as by the concerned PHS agency for scientific merit and relevance to health priorities. The work is usually carried out by foreign investigators in cooperation with a U.S. Project Officer who may be on the staff of one of the health agencies or associated with a U.S. university, hospital, or other institution. Often, the U.S. Project Officer is carrying out similar research in his own laboratory or program and the foreign investigation complements and strengthens his own work. A significant benefit derived by the foreign countries is the opportunity for their researchers to enhance their own capabilities through collaboration and exchange of information with U.S. scientists.

The activities funded by this appropriation support research projects related to the domestic activities of the health agencies. It enables them to take advantage of unusual research opportunities in the excess currency countries; strengthen communication and exchange of information between institutions here and abroad; and, as an ancillary benefit, improve relationships with other countries.

Frequently, the cost of conducting the work abroad is less than it would be in the United States. This may be due to factors such as easy accessibility to a study population, the existence of specialized laboratories, the availability of non-human primates for research, language competence, and the like.

Cooperation on health related matters by the United States with the Arab Republic of Egypt and India are expanding. Specifically, a Joint Working Group on Medical Cooperation, for which DHEW has lead responsibility, has been established with the Arab Republic of Egypt. Priority areas for cooperation have been identified and the health agencies are developing a significant number of new project proposals. Similarly, a U.S.-India Joint Cooperation Commission was established in 1974. Within the framework of that Commission, priority areas for cooperation with India in the health field have been identified, and a considerable number of new projects are being developed. A rigorous and productive cooperative health program with the Arab Republic of Egypt and India is emerging, and the tradition of excellent cooperation which the PHS agencies have had with Poland, Tunisia, and Pakistan is continuing. The goals and objectives to be carried out under this Program are:

Alcohol, Drug Abuse, and Mental Health Research

The overall objectives of the alcohol, drug abuse, and mental health research projects supported by this activity continue to be derived from the mission and priorities of the Alcohol, Drug Abuse, and Mental Health Administration; namely, mental and emotional illness.

An effort is being made to develop effective methods of preventing alcoholism and problem drinking through research which will provide a knowledge and technique breakthrough. Comparison of different treatment approaches being utilized in other countries may assist the United States in improving its own programs. A project covering both epidemiological aspects and an evaluation of different treatment modalities is under consideration for development in Poland.

The abuse of drugs is producing increasing social and public health problems in the United States. The widespread use of marijuana and other mind-alerting drugs has resulted in the need for diversified research to assess the health consequences of their use. Several drug abuse projects are being planned for the Arab Republic of Egypt, India, and Pakistan, utilizing unique populations.

Mental Health projects being developed include an extension of the nine-nation World Health Organization International Pilot Study of Schizophrenia into the Arab Republic of Egypt and in India biofeedback studies of the relationship between Yogis techniques and neurological and higher nervous functions.

Disease Prevention Research

Research in this category is directed toward prevention or control of communicable and vector-borne diseases, improving laboratory performance, nutrition, and assuring safe and healthy working conditions.

In 1977, emphasis will continue to be placed on collaborative studies of relevance to domestic program objectives, including leprosy, filariasis, malaria, and schistosomiasis.

In the Arab Republic of Egypt, ongoing studies on schistosomiasis and streptococcal diseases will be continued. Studies on diarrheal and parasitic diseases, which will complement research now being conducted at the Center for Disease Control, are under consideration. In the field of occupational health studies of industrial chest diseases will be continued and new research to determine the role of nutrition in increasing tolerance to environmental stress as well as studies of industrial noise will be initiated.

In Poland, studies on immunological responses to Staphylococcal infection and investigations of virus infections, particularly to define the immune responses of influenza and measles will be continued. Chemotherapy studies of newly-detected pulmonary tuberculosis and non B viral hepatitis in Polish children are planned. Studies of the role of arboviruses in human diseases are planned for Pakistan.

Food and Drug Research

Research projects under this activity fall into four broad areas: environmental health, radiological health, medical devices, food research and nutrition.

In this connection, the Food and Drug Administration has responsibility under the National Environmental Policy Act of 1969 for the assessment of the environmental implications of the production, use and disposal of substances subject to its regulatory authority. Moreover, FDA is required to determine the validity of test methods such as experimental ecosystems, which are used to demonstrate the "metabolism" of regulated substances by the environment. To meet this need, FDA is interested in sponsoring collaborative research under this activity which will serve to provide guidance to industry and the agency on research methodologies that may be employed to evaluate the environmental impart of substances subject to its regulation.

Projects conducted and proposed under the Special Foreign Currency Program augment the domestic radiological health program through study and evaluation of the biologic effects and health hazards of exposure to radiation such as X-rays, microwaves and ultrasound. Proposed studies during 1977 will extend these investigations into the field of light radiation exposure.

There is a continuing need to do comparative studies of the safety and efficacy of the contraceptive agents, pills, foams, diaphrams, condoms and intrauterene devices. Studies are being planned to obtain scientific and medical data in order to advise consumers and the medical community.

The excess currency countries are a valuable laboratory for studies of foods and nutrition. During 1977 emphasis will be on problems involving hazards and safety aspects of food or food contaminants. Projects would include studies of nitrosamines; natural plant toxins; mycotoxins; pathogenic bacterial and protozoa contaminants of foods; pesticide residues; toxic elements, such as cadmium, mercury, zinc, arsenic, fluoride, and selenium; and, unconventional proteins as food ingredients. Projects to investigate the teratogenic, mutogenic and caranogenic aspects of food additives and contaminants are also planned.

In the field of biologics, a collaborative research project involving viral vaccines, including the development and control of live polio virus and measles products, is planned for the Arab Republic of Egypt.

Health Services Research

The broad objective of the health services research supported under this appropriation is to improve the quantity and quality of the delivery of health services through problem-oriented research studies. Within this broad frame of reference, specific programs of concern include the provision of health and medical care to areas of need such as barriers to obtaining service; and maternal and child health, with special attention to nutrition and family planning.

The activities proposed for 1977 relate to these program areas include one project in India and three in Egypt aimed at improving the delivery of health services in remote and medically underserved areas and in other areas where facilities are underutilized. A study dealing with emergency medical services is also under consideration.

Several projects concerned with problems of maternal and infant care and of children and youth are under consideration. Egypt has expressed interest in projects relating to premature care, nephrology, and upgrading the renal disease program in the Ministry of Health. A family planning project to test new approaches to the delivery of family planning services as well as examine methodologies for motivating contraceptive users. It is expected that one or two projects will be developed, also in Egypt, dealing with the nutritional problems of adolescent mothers and their offspring. In India a project relating to malnutritional eye diseases is under discussion.

Health Resources Research

The health resources research supported under this appropriation is designed to further domestic research goals and objectives such as the development of additional health resources; improving methodologies for the continuing collection and analysis of data on the health status of U.S. citizens; and, the identification and correction of current and anticipated imbalances, inefficiencies and deficiencies in the distribution, supply, utilization and cost of health resources and services. Some of the areas now being studied under this activity are the training and proper utilization of special categories or professional and allied health manpower, cost reduction on hospitalization, and more resource opportunities for disadvantaged persons.

Comparative studies of foreign health profession eduction systems and manpower planning units and techniques are under consideration for funding in 1977. For example, a feasibility study of a new approach to primary care using village workers is under development in India. Several health manpower projects are currently under development in Egypt, including a program aimed at training secondary-level health teachers in educational, audio visual and evaluative techniques.

In the area of health statistics, a number of studies directed toward improving methodologies for vital registration and statistics development with special emphasis on more accurate indication of the health of population groups are planned. These include a study of the health status and development of school children in Egypt and a study of fetal growth, birth weight and infant growth. The latter project may provide insight into the reasons for the relatively high rate of infant mortality in the United States. Plans are under way to initiate evaluative studies of the effectiveness of urban health care. This is an area of interest to the Department in light of development on national health insurance

and the planning already under way for implementation of the National Health Planning and Resources Development Act.

Biomedical Research and Health Science Communications

The Special Foreign Currency Program is an integral part of the biomedical research and health science communications programs of the National Institutes of Health. It provides a resource whereby both intramural and extramural domestic research programs can be extended into the international biomedical sciences community--in some cases to provide needed augmentation of parallel research efforts of the United States and in other cases to utilize research opportunities not available in this country.

Biomedical research efforts are directed toward the elucidation and understanding of fundamental biological processes in normal life and disease states of man and living experimental models. This activity includes reproductive physiology, nutritional and metabolic mechanisms, cardiovascular disease, cancer studies, as well as communicable and parasitic diseases.

Parasitic infections are a health problem throughout the world, and drug treatment of these infections and chemical control of vectors such as snails and mosquitoes are decreasingly effective. Hence, the immunology of parasitic infections offers a productive new avenue of investigation. Enhancement of immune response to larger parasites offers a potentially effective therapeutic approach and a means of biological control of these debilitating, often lethal agents. Host-parasite relations of these larger organisms, which have not been studied extensively because of their complexity, also offer new models for investigating poorly understood immunological mechanisms for which a unifying theory is needed. Initial studies of some aspects of filarial infection will be undertaken collectively, and the potential for extending collaboration into investigations of the immunology of malaria will be assessed. Other biomedical problems are posed by tuberculosis and leprosy.

The widespread occurrence of bladder cancer in Egypt, associated with infection by the schistosome, a blood fluke, will be the basis for an extensive collaborative investigation. Other forms of cancer will be studied also. An apparently unusually high incidence of stroke in young people in India offers an opportunity for further study of the relationship of diet to cardiovascular complications and stroke.

Emphasis under the health science communication activity will continue to be on translation of important medical literature and publication of critical reviews analyzing current trends in biomedical research and health practice.

Scientific Activities Overseas (Special Foreign Currency Program)

Program Purpose and Accomplishments

Activity: Foreign health research (Agricultural Trade Development and Assistance Act of 1954, as amended, Section 104(b); International Health Resource Act of 1960, Section 3)

| 1976 | | 1977 | | |
|---|---|---|---|---|
| | | | Budget Estimate | |
| Pos. | Amount | Authorization | Pos. | Amount |
| --- | --- | Indefinite | --- | $1,500,000 |

Purpose: Collaborative health research and research-related projects abroad are supported by foreign currencies owned by the United States which have been determined by the Treasury to be in excess of normal United States needs in the countries. The program helps achieve the domestic health objectives of the Department and promotes United States foreign policy.

Explanation: The Program is supported entirely by foreign currencies owned by the United States abroad. Payments are made for necessary expenses for conducting research and other related activities, as authorized by law.

Accomplishments in 1976:

During 1976 an estimated $13,124,000 in foreign currencies will be obligated for new and continuations of ongoing activities in six countries. Plans include $3,808,000 for the programs of biomedical research and health science communications, $825,000 for mental health, including drug abuse and alcoholism; $3,125,000 for prevention and control of communicable diseases and occupational health; $1,280,000 for studies focused on food and drug safety, radiological health and medical product safety; $4,086,000 for studies aimed at improving the organization and delivery of health services, health statistics, medical education and other manpower development.

Objectives for 1977:

The 1977 program will be carried out in part with funds appropriated but unused in prior years. Obligations during 1977 are expected to include: $737,000 for mental health, alcoholism, and drug abuse; $3,371,000 for disease prevention and control, including occupational safety and health; $1,072,000 for studies related to food protection, radiological health, medical devices and exchange of information in these areas; $4,173,000 for studies related to the organization and delivery of health services, including health manpower and maternal and child health; and, $4,454,000 for biomedical research and the health science communications program of the National Library of Medicine.

Transition Quarter Analysis

| | Amounts Available for Obligation | |
|---|---|---|
| | 1976 Estimate | Transition Quarter |
| Foreigh Health Research: | | |
| Unobligated balance, start of period | $27,443,000 | $14,319,000 |
| Unobligated balance, end of period | -14,319,000 | -12,307,000 |
| Total obligations | 13,124,000 | 2,012,000 |

Funds are required for the transition quarter to enable the health agencies to initiate activities on a timely basis in connection with the U.S.-Egypt Joint Working Group on Medical Cooperation, the U.S.-India Joint Cooperation Commission and the U.S.-Polish Program of Cooperation in the Health Sciences. Each of these Programs involved a Government-to-Government Agreement through which priority areas for cooperation have been identified for support.

## 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:]

IMMUNIZATION

Obligations for Immunization

| | 1973 | 1974 | 1975 | 1976 Estimate | 1977 Estimate |
|---|---|---|---|---|---|
| Center for Disease Control: | | | | | |
| Grants..... | $10,050,000 | $10,650,000 1/ | $6,200,000 | $4,960,000 | $4,960,000 |
| Direct operations... | 1,040,000 | 1,228,000 | 1,339,000 | 1,384,000 | 1,384,000 |
| Total ..... | 11,090,000 | 11,878,000 | 7,539,000 | 6,344,000 | 6,344,000 |

Since 1963, project grants have been awarded to State and local health agencies to assist them in planning, developing, and conducting immunization programs. Initially grants were awarded to assist health agencies in developing and implementing mass immunization programs against poliomyelitis, measles and rubella shortly after licensure of live vaccines against these diseases. These programs were generally oriented toward a single disease and accounted for substantial reductions in morbidity and mortality from the diseases.

As the large reservoirs of susceptibles for poliomyelitis, measles, and rubella were individually reduced, comprehensive immunization programs directed toward all of the major vaccine preventable diseases of childhood were supported to maintain the decline in morbidity and mortality which had begun.

During calendar year 1974, reported cases of these diseases reached all time lows. However, during 1975, both measles and rubella increased from the number of cases reported in 1974 (10% and 37%, respectively), and there still remain unprotected some 18 million children against polio, 22 million against diphtheria, pertussis, and tetanus, 11 million against measles, 16 million against rubella, and 31 million against mumps. In addition, there has been a significant decline in the number of doses of vaccine distributed through public programs during the period 1972 - 1975.

All States and territories will continue to receive immunization project grant assistance in 1976 and 1977, although States and communities will be expected to assume responsibility for supporting a greater share of the cost of public programs.

The Center also provides technical assistance to States and localities, and is continuing to coordinate a nationwide public and professional awareness program, called Immunization Action Month, which is attempting to revive interest among parents and physicians in insuring that children receive adequate immunization.

1/ Includes $4,450,000 of 1973 funds restored in 1974.

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Rh Hemolytic Disease 1/

The use of MCH formula funds by State Health Departments to provide Rh immunoglobulin in their maternity services for Rh negative women at risk, has contributed to the increased utilization rate of this preventive procedure and the general decline of Rh Hemolytic Disease.

The liberalization of State abortion laws and the recent dramatic increase in the early termination of pregnancies however, may well be negating some of this progress. An Rh negative woman can become immunized by the spontaneous or induced abortion of her Rh positive fetus if she is not protected by administration of Rh immunoglobulin. Utilization rates of RhIG after abortion has been far from ideal. This is an area of prevention which will require particular attention.

1/ Obligations not identifiable

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Rubella 1/

The numbers of children with suspected and confirmed congenital rubella syndrome being cared for by the MCH supported special clinics for mentally retarded children and by the crippled children's program has shown a considerable decrease. The concern about a general decline in immunization levels in our population in recent years, however, also relates to rubella. The protection of females of child bearing age remains the objective of the rubella immunization campaign. This objective is being achieved primarily by mass immunization of children who are the major sources of virus dissemination in the community. Surveillance reports from CDC indicate that vaccination levels through the nine year old group have improved significantly, reaching over 60% of the children. While there is a clear trend towards an increasing immunity level in women during child bearing years, these figures still leave considerable room for the potential recurrence of significant numbers of infants with congenital Rubella syndrome.

1/ Obligations not identifiable

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Pediatric Pulmonary Centers

Obligations
(in thousands)

| | 1972 | 1973 | 1974 | 1975 | 1976 Estimate |
|---|---|---|---|---|---|
| Public Health Service: | | | | | |
| Health Services Administration..... | $756 | 0 | $1,498 | $2,000 | $2,000 |

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.

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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.

1/ For further detail, see Cystic Fibrosis, NIH

In-patient care is available for complex diagnostic problems or acute exacerbation of the disease which cannot be managed at home.

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 graduated 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 children 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 corsortia 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, psychiatry, 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 suspician, 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 years 1974 and 1975 obligated funds up to $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 all but one of the Centers. Short-term programs such as seminars, workshops, and in-service education have been offered for practicing physicians, nurses, respiratory therapists, nutritionists and other professional workers in all ten centers. In fiscal year 1976, Bureau of Community Health Services funds supported long-term training of 28 physicians and 69 other health professionals and short-term training of two physicians and 21 nurses. Non-BCHS-supported trainees in the ten centers numbered 2,158 in the same year.

VENEREAL DISEASES

Obligations
(In Thousands)

| | 1973 | 1974 | 1975 | 1976 Estimate | 1977 Estimate |
|---|---|---|---|---|---|
| Public Health Service: | | | | | |
| Center for Disease Control | | | | | |
| Grants | $24,800 | $24,800 | $28,000 | $19,840 | $19,840 |
| Direct Operations | 6,540 | 7,513 | 8,230 | 8,524 | 8,524 |
| National Institutes of Health | | | | | |
| National Institute of Allergy and Infectious Diseases | 1,085 | 2,937 | 3,069 | 4,084 | 6,134 |
| Total | 32,425 | 35,250 | 39,299 | 32,448 | 34,498 |

In the last two decades, syphilis and gonorrhea have re-emerged as significant health threats to the United States. In recent years, other sexually transmitted disease have also increased -- disease such as genital herpes virus, non-specific urethritis, and trichomoniasis.

The Federal Government is meeting the health threats of syphillis and gonorrhea by assisting States, through grant programs and technical assistance, to mount more effective control programs, while also intensifying basic and applied research programs.

The major Federal foci for state assistance are the Center for Disease Control (CDC) and the DHEW Regional Offices; and for research, they are the CDC and the National Institute of Allergy and Infectious Diseases (NIAID). In addition to major investments in syphilis and gonorrhea, the CDC and NIAID are sponsoring research studies in the other sexually transmitted diseases.

The CDC and NIAID programs are more fully described in the following sections.

CENTER FOR DISEASE CONTROL

Almost since their beginning, venereal disease control efforts have been carried out through a partnership of Federal, State, and local governments, private medicine and voluntary organizations. This shared responsibility has decreased the prevalence of syphilis, from a high of 575,593 in Fiscal Year (FY) 1943 to 82,397 in 1975 -- almost one-half million cases less. More specifically, since FY 1940, infant deaths from syphilis have declined 99 percent, first admissions to mental hospitals with psychoses caused by syphilis have declined 98 percent, and reported cases of congenital syphilis have declined 94 percent. In 1940, over 14,000 deaths were caused by syphilis. By 1974, the last year for which data are available, deaths had declined to 240 -- a decrease of 98 percent. Today most congenital syphilis is discovered among adults who were born with the disease in past era of higher disease incidence. Of the 1,024 congenital cases reported in FY 1975, only 221 were among infants under 1 year of age.

Although the number of reported cases of syphilis in all stages continued the declining trend in FY 1975 when 82,397 cases were reported (a decline of 2.1 percent from the 84,164 cases reported in FY 1974), the trend in reported infectious syphilis continues to be mixed. Control efforts are now focused on preventing new (i.e., infectious) cases of syphilis, since successful inroads have been made in reducing the reservoir of untreated syphilis of long duration. During the 35 years that data have been collected, the trend in reported cases of primary and secondary syphilis, usually interpreted as paralleling the actual occurrence of syphilis, has changed direction several times. During and shortly after World War II, reported infectious syphilis cases increased, to peak at 106,539 in FY 1947. Reported cases declined by as much as 50 percent per year after 1947, reaching an all-time low of only 6,351 cases in 1957. In 1958, infectious syphilis increased only slightly, but by 1960 and again in 1961 the increase measured about 50 percent per year. In 1962, Federal efforts to control syphilis were intensified and the rate of increase slowed, with reported cases reaching a peak of 23,250 cases in FY 1965.

Cases again began to decline in FY 1966 and decreased by almost 1,000 cases annually until 1970. Between FY 1970 and FY 1975 reported cases increased -- except in FY 1974 when they decreased 1.4 percent over 1973. In FY 1975, reported cases of primary and secondary syphilis numbered 25,746 cases, an increase of 4.1 percent over the cases reported in FY 1974. Male cases accounted for 71.5 percent of those reported, an increase of 7.8 percent over FY 1974; and female cases accounted for 28.5 percent, a decline of 4.2 percent from FY 1974. Provisional data for the first two months of FY 1976 suggest that the trend of early syphilis is again changing. Reported primary and secondary syphilis cases declined 8.9 percent during August 1975 over reported cases for August 1974 -- the fourth such successive monthly decline. The challenge of reducing the incidence of syphilis, although not aided by the availability of an immunizing agent, can be successfully met with existing epidemiologic and educational tools if they are applied consistently and intensively on a national basis.

The trend of reported cases of gonorrhea in the United States closely followed that of infectious syphilis from FY 1941 through FY 1965 in direction but not in the magnitude. Since 1965, while the trend in infectious syphilis fluctuated both upward and downward, gonorrhea increased steadily.

In FY 1973, federally assisted State and local programs to control gonorrhea were first implemented. Although the increasing incidence in reported cases has slowed from 12.7 percent in FY 1973 to 7.4 percent in 1975, gonorrhea still ranks first among all reportable diseases. During 1975 there were 938,778 reported cases of gonorrhea, an increase of 64,617 cases (7.4%) over the number reported in FY 1974. Trends in reported cases continue to differ for men and women. During FY 1975, reported cases in men numbered 557,058, an increase of 6.5 percent; and in women, 381,720, an increase of 8.8 percent over the number of cases reported in FY 1974. The disparity in reported cases between men and women is being closed, since a major emphasis of the control program is to identify and provide treatment to women who typically are infected (and infectious) without any early discomfort which would prompt them to such medical care.

Gonorrhea continues to be reported most frequently from the 63 large urban areas with populations of 200,000 or more, although 23 cities (36.5%) reported a decrease during FY 1975. Together, these 63 areas, comprising 28 percent of the nation's population, accounted for 53.4 percent of the reported cases during FY 1975, an increase of 4.2 percent over FY 1974, compared to an increase of 11.3 percent for the rest of the nation.

Wide variations among states in reported gonorrhea case rates characterize the geographic distribution of this disease problem. However, some of these differences in reported case rates reflect differences in casefinding activity, availability of public clinics, and reporting practices rather than differences in attack rates. In FY 1975 the highest gonorrhea rates per 100,000 population were reported by Alaska, 1125.7; Georgia, 923.9; Florida, 814.4; South Carolina, 789.2; and Tennessee, 764.3; and the lowest by North Dakota, 121.2 and New Hampshire, 105.1.

The age distribution for both syphilis and gonorrhea are similar and show the 20- to 24-year old age group to be at the greatest risk of acquiring infection. Among gonorrhea patients, the second highest risk group is teenagers (15-19 years of age), and for syphilis patients it is the 25- to 29-year old age group.

Major emphasis continues to be placed on developing and implementing control programs which focus on disease intervention activities designed to reduce the incidence of these diseases. The major components of these programs are (1) screening high-risk female populations for gonorrhea; (2) surveillance of syphilis through serologic screening of specific population segments; (3) providing contact referral services to patients with infectious syphilis and gonorrhea; (4) providing venereal disease facts to people at risk to prevent exposure to venereal disease and to influence infected individuals to seek early medical care; and (5) involving the private medical community in all aspects of venereal disease control.

In screening programs for gonorrhea during FY 1975, 8,863,899 culture specimens were obtained from women, of which 375,863 (4.2%) were positive for gonorrhea, and treatment was documented for 92 percent of these infected women. Although positivity rates were highest (19.0%) among venereal disease clinic patients, some 91 percent of all tests were performed in other settings. In these other settings, positivity rates ranged from a low of 1.7 percent among dependents of military personnel, at student health centers, and among private family planning groups, to a high of 5.1 percent among women who were tested in detention centers. Private physicians obtained test specimens from 2,492,435 women, of which 48,683 (2.0%) were positive for gonorrhea.

In addition to screening efforts, outreach medical coverage for at-risk groups resulted in the contact-referral process being applied to 301,506 patients during FY 1975. This interview contact-referral procedure resulted in 207,982 contacts to gonorrhea patients being examined and 171,393 persons being treated therapeutically or preventively.

Because of gonorrhea screening and other outreach efforts, infected women are being treated earlier in their infection and thereby removed from the infectious reservoir and prevented from further spreading the disease and from developing serious complications. Since positivity rates from gonorrhea testing programs have remained relatively stable at 4.2 percent, the incidence of gonorrhea among women may be stabilizing.

As indicated by recent studies, the complications of gonorrhea in women are serious and costly. In one study area pelvic inflammatory disease (PID) occurred in 17 percent of all women known to have gonorrhea, and 4.5 percent of women with PID were surgically sterilized. If these percentages are applied nationally, some 220,000 cases of PID occur yearly, resulting in the surgical sterilization of 9,900 women during their childbearing years. Additional data from Sweden suggest that sterility occurs in 15-40 percent of women after one episode of PID. Such results indicate that from 33,000 to 80,000 women become sterile annually in the United States from PID. The estimated national costs of the complications of gonorrhea in women amounts to $211,893,000 annually, including about 175,000 hospital admissions totaling 1.2 million hospital days. Because of the serious complications of gonorrhea in women, research efforts continue to focus on defining additional risk factors, diagnostic techniques, and therapeutic modalities for PID.

Syphilis control efforts are focused on disease-intervention activities, including case detection, surveillance and prevention. Almost 42 million serologic tests for syphilis were performed during FY 1975. Of these, 1,066,685 tests were reactive, and 65,606 persons were determined to be infected with syphilis.

The epidemiologic process applied to early syphilis cases is directed toward preventing infection through treatment of persons in the infectious stages before they spread the disease and toward preventing disease by treating sexual contacts while they are incubating disease. During FY 1975, the syphilis epidemiologic process was applied to 44,795 early syphilis patients. Medical examinations were provided to 127,123 named suspects, resulting in the detection and treatment of 12,987 new cases of syphilis and the prevention of an estimated 3,200 additional new cases of syphilis.

Because of population mobility and a high rate of interstate and international disease transmission, program efforts are directed at ensuring the rapid exchange of contact information between program areas. More than 12 percent of all reported sexual contacts to known syphilis cases during FY 1975 resided in States or countries other than those in which the original patients received treatment. Every State, the District of Columbia, Puerto Rico, and the Virgin Islands exchanged contact information with at least one other program area in FY 1975. Information was exchanged, on an interstate and international basis, on 12,810 syphilis contacts in FY 1974 and 15,069 in FY 1975, an increase of 17.6 percent. This exchange of contact information in FY 1975 resulted in the examination of 8,353 (55.4%) persons, and, of those examined, 716 (8.6%) were treated for a previously undetected syphilis infection.

Sexually transmitted diseases (STDs) other than the five traditional "venereal" diseases continue to be increasingly recognized as major public health problems because they produce severe morbidity, cause patient loss of productivity, and impose enormous demands on medical care facilities. Among the most important STDs are nongonococcal urethritis, with an estimated incidence of more than 2.5 million cases annually; trichomoniasis, with an estimated incidence of more than 3 million cases annually; and genital herpes, with some 300,000 cases annually. Data obtained from a national survey of private physicians found that for every 100 cases of gonorrhea treated by private physicians, approximately 57 cases of nongonococcal urethritis, 204 cases of trichomoniasis, 11 cases of genital herpes, 10 cases of pediculous pubis and 27 cases of venereal warts were treated. Studies also indicate that the comparative incidence of nongonococcal and gonococcal urethritis varies greatly from area to area and from population to population. One study found that an average of 3.8 and 7.4 cases of gonococcal urethritis (GC) and nongonococcal urethritis (NGU), respectively, were seen by each physician in a 3-month retrospective survey of 2,118 practicing physicians; the ratio of NGU to GC cases treated by private physicians was 2:1, but in eight area public VD clinics it was 1.7:1. An estimated 68 percent of all male gonorrhea cases occurring during the study period were treated by other than public clinics and no more than 5.8 percent were actually reported. In the study area the annual incidence of male gonorrhea was estimated to be 16.2 per 1000, and male NGU, 29.0 per 1000. A retrospective survey of conjunctivitis cases in newborns in a large metropolitan hospital has shown that chlamydia causes four times as much conjunctivitis as the gonococcus. This form of conjunctivitis, called "inclusion conjunctivitis," has seasonal peaks similar to those of other venereal diseases. To quantitate the sexually transmitted diseases and to identify populations at greatest risk of infection, the CDC has established eight geographically dispersed disease monitoring sites.

Educational efforts are directed primarily at high-risk populations -- persons with a history of repeated infections -- in an attempt to reduce further reinfection and transmission. Methodologies are being developed for evaluating the strengths and weaknesses of alternatives for delivering venereal disease education in school systems. "VD Update" courses provide advanced training in the case management of venereal disease patients to teachers of venereology, clinicians, and directors of venereal disease control programs, and other health professionals responsible for health care services. Other educational programs emphasize the involvement of health care providers in all aspects of the venereal disease control effort.

The private medical community continues to play an important role in venereal disease control. Program activities with the private medical community are designed to inform the private physician of the venereal disease control effort, to elicit his participation in all aspects of the control program, and to provide him with diagnostic and treatment information. Physicians are encouraged not only to diagnose properly and treat effectively, but also to simultaneously treat sex partners and involve patients in the referral of their sex partners to medical care.

In addition to its responsibilities in implementing national control programs, the Center for Disease Control plays an important national role in conducting and stimulating venereal disease research. The CDC's primary focus is operational research aimed at the practical application and evaluation of newly developed techniques of venereal disease control, including clinical and basic venereal disease research as it relates to disease epidemiology and control methodologies.

An essential factor in the control of gonorrhea is the availability and use of effective therapeutic regimens. To meet this need the Center established a monitoring system to evaluate current CDC recommendations for the treatment of uncomplicated gonorrhea, to test new treatment regimens and antibiotics recommended for the treatment of gonorrhea, and to monitor organism antibiotic resistance and adverse patient drug reactions. All regimens continue to be highly safe and effective with recurrence rates of less than 5 percent. Although all geographic areas have some highly resistant strains of Neisseria gonorrhoeae, the system has documented that resistance has not increased significantly in the past 4 years.

Several clinical factors influencing therapeutic efficacy in gonorrhea have been elucidated through this therapy monitoring study. These include the patient's weight, the susceptibility of the gonococcus to antibiotics, the amount of the drug administered, and the sex of the patient. These variables influence cure rates by their effect upon the serum levels of antibiotics attained after treatment. Such data confirm the fact that adequate antimicrobial dosage remains the most important factor in gonorrhea treatment. The monitoring system has also supplied useful information on reinfection rates, which increased from a low of 0.4 percent at 1-3 days after therapy to about 20 percent at 16-18 days after treatment. The study also demonstrated that the gonorrhea therapy regimens recommended by CDC are equally effective in treating endocervical and anal canal infections in women. The auxotype system developed and improved by NIAID researchers has been applied to the CDC collection of gonococcal isolates from the therapy monitoring network. Significant regional variation in the types of gonococci was noted -- an important factor to consider in developing gonococcal vaccines. CDC plans to maintain the surveillance on gonococcal resistance, to test new drugs for efficacy, and to further explore the meaning of auxotopic variation of gonococci.

Other clinical studies have demonstrated that parenteral erythromycin is an effective treatment for disseminated gonococcal infection but oral erythromycin is ineffective for uncomplicated gonococcal infection. A separate study demonstrated that two potentially useful short-dosage regimens of sulfa-trimethoprim are not useful for treating gonorrhea.

Basic control models for syphilis and gonorrhea have been developed. The developmental process of these models has caused venereal disease control programs to more clearly focus on unresolved or poorly understood facets of disease transmission and on resource allocations to maximize disease control results. In addition to these basic statistical models, further statistical research is being pursued. These newer studies will test predictive values of statistical analysis and the seasonal variation of gonorrhea, and explore the hypothesis that the gonorrhea epidemic is being maintained by a central core population of particularly effective transmitters of the disease.

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.

A major problem in controlling gonorrhea is the repeatedly infected patient. A recent study showed that only 0.06 percent of the population in the study area accounted for 21.6 percent of the reported gonorrhea cases and may have been responsible for more than one-half of all disease transmissions. The study group was composed of 492 patients who had acquired two or more infections over a 12-month period and who tended to be young, to live in intercity areas, and to drop out of high school. Although these repeater patients did not tend to have greater numbers of different sex partners or more frequent contact with prostitutes, they less frequently brought their sexual partners with them to medical examination. Because of this problem, educational efforts directed toward health care providers and high-risk groups emphasize the need for the simultaneous treatment of sexual partners.

The CDC also plays a significant role in the maintenance of high-quality diagnostic laboratory services. Research in new developments and ongoing maintenance of methods for laboratory training, proficiency testing, and reagent standardization continues to receive high priority. The Center has also contributed significantly to the understanding of the basic bacteriology and immunology of venereal diseases, including developing a standard selective culture medium for N. gonorrhoeae; discovering and describing two types (Types I and II) of virulent colonies of N. gonorrhoeae which are the source of gonococcal pili; measuring the in vitro antibiotic susceptibility of N. gonorrhoeae from 1950 to the present; developing systems for the transport of N. gonorrhoeae culture specimens; and applying gas liquid chromatography as a diagnostic test on body fluids.

Researchers at the CDC developed the FTA-ABS test for syphilis, (now the standard confirmatory test) reevaluated the CSF-FTA-ABS and the 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 CDC; these animal models have been the basis for advances in understanding the pathogenesis and immunology of both diseases.

With a marked increase in the number of 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, a comprehensive real-world reevaluation of the performance of the FTA-ABS test is being carried out through the cooperation of more than 20 State health department laboratories. Also, studies to determine the relative values of other serologic tests for syphilis have been undertaken. The hemagglutination tests for syphilis antibody, recently marketed in the United States, have been shown to be as specific as the more cumbersome FTA-ABS test in a prospective evaluation of more than 800 patients and holds promise of being a practical alternative test.

As a result of the study of referred specimens and because test results were not clinically useful, the expensive TPI test has been discontinued.

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.

During 1977, the gonorrhea therapy monitoring system will continue to survey the antibiotic resistance of the gonococcus, the efficacy of treatment recommendations, and the adverse reactions to therapy. Special studies will also be conducted to ensure the efficacy of therapy recommendations in the special areas of treatment of the penicillin-allergic patient, gonorrhea in children, and the complications of gonoccocal infection, particularly pelvic inflammatory disease (PID).

Among women, PID is one of the most serious complications of gonorrhea. Although major emphasis will continue to be placed on preventing the transmission of primary disease, reinfection, and relapse, renewed research efforts will be undertaken to define additional risk factors, diagnostic techniques, and therapeutic modalities for PID. Prospective evaluations of in- and outpatient therapy for PID have been initiated. Results from these studies will form the basic framework for a National PID symposium to be held at the Center in March 1977.

Although currently available serologic tests developed for screening populations for gonorrhea lack the desired levels of sensitivity and specificity, efforts to develop an acceptable test will continue. Basic to the development of such a serologic test is a bank of well-characterized sera from patient populations with relative low prevalences of gonococcal infection (3-8 percent). The CDC will continue to expand its bank of characterized sera through research efforts with universities, private health care providers and official health agencies.

Emphasis in the gonorrhea screening program is shifting from all sexually active women to posttreatment and periodic rescreening of both male and female gonorrhea patients and to increased counseling of patients to refer their sexual partners for diagnosis and treatment. This shift in emphasis is to discover infection or reinfection quickly within this population and thereby significantly interrupt the spread of disease.

In recent years, the male homosexual's role in acquiring this disease has apparently increased. More cost-effective VD casefinding approaches among this population will be sought, with emphasis on establishing contact with the gay community, implementing VD and other STD screening and education programs for this population, and improving relationships with the private medical community that provides VD services to homosexuals.

In syphilis research, the focus will continue on developing a medium for culturing Treponema palladum in vitro, a necessity for refining serologic tests, developing a syphilis vaccine, and expanding our knowledge about the pathogenesis of syphilis. Studies are being conducted in the growth of T. pallidum in a hemodialysis system and in various animal models.

The social aspects of VD, recognized since the early part of the 20th century, probably have contributed to the recent increases in reported cases. Therefore, efforts will be pursued to measure the impact of these social factors on disease spread and to develop intervention strategies based on understanding the behavioral aspects of venereal disease control.

Efforts will be expanded to develop control measures for a number of STD's other than syphilis and gonorrhea because of their increasing national significance. These expanded efforts, comprising a balanced program to support the development of control methodologies, education and operational research, include: (1) establishing adequate disease surveillance to assess and define the magnitude of the disease problem, (2) assessing various disease control techniques designed to reduce the incidence and prevalence of these diseases, (3) increasing the efficiency of collecting patient data, expediting patient care and improving the collection of epidemiologic information, and (4) performing selected studies on the epidemiologic aspects of these diseases.

## Venereal Disease Services to Indians

The American Indians, Eskimos, and Aleuts receive venereal disease control services through VD project grants awarded to State and local health departments by the Federal Government. Approximately one-half of the 800,000 Indians living in the United States are eligible for health services provided through the Indian Health Service facilities located in 24 States. The State health department and the individual Indian Health Service facilities jointly coordinate the VD control efforts and services in each State.

In late FY 1972, as the national gonorrhea control program was being implemented, CDC 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 through State health departments, as supplemented with Federal grants, with the Indian Health Service providing clinical services.

Gonorrhea culture screening and follow-up services are established and functioning well at most Indian Health Service medical facilities. The number of women screened has continued to increase each year since the program was formally initiated during FY 1973:

| | Screened | Positive | |
|---|---|---|---|
| | (No.) | (No.) | (%) |
| FY 1973 | 38,443 | 2,405 | 6.3 |
| FY 1974 | 49,274 | 2,427 | 4.9 |
| FY 1975 | 58,892 | 2,825 | 4.8 |

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.

Among Indian populations the VD control program in the Navajo Area is the most complex in terms of the level of disease incidence and the coordination effort required. 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, supplemented with Federal grants. In addition to these resource inputs, the Indian Health Service has a contract with the Navajo Tribal Council to furnish outreach services in support of the VD control program.

NATIONAL INSTITUTES OF HEALTH

National Institute of Allergy and Infectious Diseases

## The NIAID Effort in Research on Sexually-Transmitted Diseases

The National Institute of Allergy and Infectious Diseases (NIAID) continues to serve as the focus of a multi-faceted national approach, through biomedical research, to the problem of venereal disease, now referred to by some experts as sexually-transmitted diseases. The inability of public education programs and contact tracing and treatment to halt the spread of sexually-transmitted diseases has emphasized the need for research to answer many of the questions that remain about these diseases.

Thus, 1975 was the fifth year of NIAID's expanded research program on this public health problem. Under NIAID support, 40 grantees, 3 program-project recipients, and 6 contractors, as well as a small group of intramural scientists, are working to improve our understanding of many sexually-transmitted diseases -- not just syphilis and gonorrhea -- in order to provide a basis for improved methods of therapy and prevention. Furthermore, in order to ensure future continuity and expertise in this field, 29 young scientists are receiving training with experienced investigators, under the support of NIAID fellowships or training grants.

In recognition of the major public health needs and the broad scope of the venereal disease problem, NIAID initiated a program of special grants supporting multidisciplinary studies in 1974. Two such program-projects were awarded that year to the University of Washington, Seattle, and Harvard University School of Public Health, and a third this year to Baylor College of Medicine, Houston, Texas. Under the latter, scientists are studying gonorrhea, syphilis, group B streptococcal infections, and herpes simplex virus infections of the genital tract.

## Gonorrhea

Gonorrhea, for several years the most commonly reported bacterial infection in the U.S., is caused by a bacterium known as the gonococcus. Its scientific name is Neisseria gonorrhoeae.

Typically, the gonococcus infects the mucous lining of the genitourinary tract. In males, this involves an acute, purulent (with pus) infection of the urethra (the canal carrying urine from the bladder to the outside of the body). In females, infection of the urethra and the cervix (opening of the womb) is usual. Newborn children may acquire a purulent infection of the eyes after passing through an infected birth canal in the mother. To prevent this and other eye infections, physicians place silver nitrate solution in the eyes of all infants immediately after birth. Complications of gonococcal infection often include sterility and arthritis, but rarely may also result in infection of the brain (meningitis) or heart (endocarditis), or the widespread presence of gonococci in the blood (gonococcemia). Physicians are also finding evidence of gonococcal infections in such other areas of the body as the rectum and throat.

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 early 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 microorganism -- for example, its growth needs, its mechanisms of action, development of immunity, and how the organism develops resistance to the antibiotics used to treat it. NIAID-supported researchers are seeking answers to problems such as these.

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 may be 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, and investigations on pili are continuing. For example, this year Dr. Thomas M. Buchanan, formerly of the Rockefeller University and presently with the University of Washington, Seattle, working under NIAID support, studied the basic makeup of gonococcal pili. By further purifying pili, using a procedure he developed, he demonstrated that pili are pure protein and contain no complex structural sugar residues.

Using purified pili from two strains of type 2 gonococci, Dr. Buchanan then determined that not all gonococcal pili are identical. Antisera (blood containing specific antibodies to a particular organism or protein) to the pili were produced. Test results then revealed the pili to be different as shown by differences between the antibodies. Recognition that gonococcal pili vary between strains will help scientists carry out genetic studies of gonococci, as well as to trace different strains that may be found in a community or geographic area. Dr. Buchanan now has an NIAID contract to try grouping gonococci according to differences in their pili or in cell wall substances.

Other attempts are being made to explain the reasons for type differences in virulence. NIAID grantee Dr. Abraham I. Braude of the University of California, San Diego, found that not only are virulent gonococci more resistant than avirulent types to killing by human serum, but also that virulent types are able to develop complete resistance to the serum of newly infected patients. That is, avirulent gonococci are not able to increase their resistance to serum killing. However, during exposure to the body's protective substances in genital secretions or during the inflammatory stage of gonorrhea, virulent gonococci may be selected out that are completely resistant to killing. Dr. Braude also found that human urine contains a factor related to its acidity that kills gonococci. This may affect the establishment of gonorrhea infections in the urethra, where urine passes over gonococci.

NIAID grantee Dr. Richard A. Finkelstein at the University of Texas Southwestern Medical School in Dallas has taken another approach to the question of gonococcal virulence. While growing the four types of gonococci in chick embryos -- an experimental animal model system he developed -- Dr. Finkelstein was able to increase the virulence of types 3 and 4 approximately 100-fold by supplementing the cultures with iron. Furthermore, although iron supplements did not increase the virulence of types 1 and 2, he was able to decrease their virulence by adding a substance which naturally binds with the iron in hen's eggs. Thus, the ability to compete with the host for iron may be an important attribute of virulence in gonococci, as it is with other disease-causing bacteria, and might even affect the type or extent of infection established in an individual.

Classification of Gonococci. Other studies of gonococcal structure may enable scientists to divide the strains of the gonococcus into a few groups (serotypes) according to antibodies formed in the blood. This, in turn, would greatly aid many studies of the bacterium, including the question of the host's immunity to infection.

NIAID grantee Dr. Michael A. Apicella of the State University of New York at Buffalo, has identified four substances or antigens on the cell wall of the gonococcus. He has designated these $Gc_1$, 2, 3, and 4. Using these antigens, he tested several systems for serogrouping gonococci and found a method known as hemagglutination inhibition (HAI) to be best. Then, using his antigens and HAI, he was able to place each of 163 clinical samples of gonococci in distinct serogroups.

In addition to the serogrouping work of Drs. Apicella and Buchanan, Drs. Kenneth Johnston, University of Texas, Dallas, and Charles Brinton, University of Pittsburgh, have been investigating this subject under NIAID contracts since June 1975. Dr. Johnston's approach is through the use of cell wall antigens, and in the past year he has expanded his number of candidate serotypes from 12 to 16. Dr. Brinton is exploring the use of gonococcal pili as a basis for serogrouping as well as their potential as a vaccine. He has begun studies in chimpanzees to determine if a pilus vaccine can be protective.

Such serogrouping of gonococci may further epidemiological studies of gonococcal infections, enhance our understanding of the relationship of the changes in antibiotic sensitivity to the different serogroups, clarify the clinical problem of reinfection, and perhaps enable researchers to develop a reliable blood test for gonorrhea.

Genetics of Neisseria gonorrhoeae and Antibiotic Resistance. By studying the genetics of a microorganism like the gonococcus, scientists can learn many things, including how changes or mutations occur and how various activities of the organism are controlled.

Experts have thought for some time that only virulent gonococci (i.e., those with pili) are able to take up new genetic material in the form of DNA (deoxyribonucleic acid) and be changed by it. This suggested a direct relationship between pili, virulence, and the ability to take up DNA. This year, however, Dr. P. Frederick Sparling, an NIAID grantee at the University of North Carolina, found mutant gonococci which, despite the presence of pili, did not take up DNA. He also identified mutant type 4 gonococci which accepted DNA and were changed by it. By thus showing that pili are not necessary for genetic transformation, Dr. Sparling may significantly increase scientists' understanding of the relationship between the surface structure and genetics of the gonococcus.

NIAID grantee Dr. Frank E. Young of the University of Rochester School of Medicine and Dentistry in New York has shown further that no unique growth conditions are required by the gonococcus for it to take up outside DNA. DNA enters the gonococcal cell easily and is resistant to an enzyme involved in the degradation of DNA. Dr. Young is now studying the size of the DNA fragment that enters the cell and the events that occur after it is inside the cell.

Studies of gonococcal genetics have already increased our understanding of the gonococcus' development of resistance to antibiotics. For more than 30 years the treatment of choice for gonorrhea has been penicillin, but in recent years recommended dosages have had to be increased significantly. Because of continued treatment failures and because an unknown number of Americans are allergic to penicillin, other antibiotics -- spectinomycin, kanamycin, and tetracycline -- are also used. There are, unfortunately, reports of strains also becoming resistant to these "second-line" drugs.

Last year several groups showed that gonococcal resistance to antibiotics may be related to a combination of several genes. Studying gonococcal strains that are resistant to more than one antibiotic, NIAID grantee Dr. Leonard Zubrzycki of Temple University School of Medicine in Philadelphia has found this year that these genes may all be on a single chromosome. Thus, resistance may be transferred by a single piece of DNA. The exact cause of this resistance remains to be determined.

By combining his studies of genetics with other investigations on antibiotic resistance, Dr. Sparling has determined that mutations for resistance to fusidic acid and spectinomycin are usually incompatible with each other. That is, when both mutations are introduced into the same strain, the bacterium will not grow. This may provide a valuable clue for future treatment of gonorrhea. Should gonococcal resistance to certain antibiotics continue to increase, the use of fusidic

acid and spectinomycin together should ensure against the development of mutants resistant to this combined therapy.

Diagnosis of Gonococcal Infections. Public health officials are in serious need of a means for easily and quickly identifying a gonococcal infection. At present, the only way to diagnose gonorrhea is to obtain a specimen -- of urethral discharge in a man, for example -- and then either directly examine the specimen under a microscope for the presence of gonococci or grow it in a laboratory culture and then look for colonies of gonococci.

One approach being explored by NIAID grantee Dr. Katharine Merritt at Dartmouth Medical School in Hanover, New Hampshire, is the use of a laboratory technique known as counter-immunoelectrophoresis (CIE). The CIE technique, which detects a specific reaction between antigen and antibody, is rapid and sensitive. Also, it does not require live microorganisms, which is important because the gonococcus is fragile and not easily transported .

Laboratory and clinical studies so far have supported the usefulness of CIE in diagnosing gonococcal infections. Dr. Merritt is now extending her evaluation to the use of CIE in a clinic. The test is rapid enough to run while a patient waits, so that a provisional diagnosis can be made before the person leaves the clinic. Tests of patients with arthritis, a common complication of untreated gonorrhea, suggest the usefulness of CIE in diagnosing gonococcal arthritis also.

Some cross-reactions in the CIE test have been observed with two other bacteria -- Haemophilus influenzae type b and the meningococcus. These organisms are not usually present in the genital tract, but because they are found in other sites where gonococci may be present, such as the pharynx, Dr. Merritt is now attempting to identify the cause of these cross-reactions.

Resistance to Infection. Scientists do not completely understand how the human body responds to gonococcal infections and why one attack of gonorrhea does not confer permanent immunity against further infection. Among the NIAID-supported researchers studying these questions are: Drs. Robert P. Williams, Baylor College of Medicine; Richard Roberts, Cornell University; William D. Sawyer, Indiana University School of Medicine; and Gerald L. Mandell, University of Virginia School of Medicine.

All four scientists are interested in the interaction between gonococci and certain white blood cells known as leukocytes. These cells usually are vital to the body's attack on an infection because they ingest and kill microorganisms. However, Dr. Mandell has shown that while type 3 (avirulent) gonococci are ingested by certain leukocytes known as polymorphonuclear leukocytes (PMN), virulent type 1 gonococci became attached to these cells, but were not ingested by them.

Following a similar line of research, Dr. Roberts has concluded that virulent gonococci possess some type of surface component that confers resistance to phagocytosis (ingestion by leukocytes) in humans. Like Dr. Mandell, he has found that virulent gonococci adhere to surface membranes of phagocytic leukocytes, while avirulent ones do not.

Also interested in PMN's, Dr. Sawyer has found that of the two leukocyte chemicals -- superoxide and hydrogen peroxide -- playing a role in the intracellular killing of bacteria, hydrogen peroxide appears to be the more important. Preliminary evidence from Dr. Sawyer's laboratory also suggests that certain structures known as lysosomes in PMN's do not discharge their enzyme contents into the local microenvironment unless the gonococcus is actually ingested by the PMN. If such discharge occurred following simple attachment, this could explain, at least in part, the local inflammation characteristic of acute gonorrhea.

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Dr. Williams is examining the relationship between PMN's and gonococci in the purulent discharge which is a cardinal symptom of gonorrhea in the male. He found that more than 95 per cent of the cells in the purulent exudate were PMN's. Furthermore, type 1 gonococci were associated with five to ten per cent of these leukocytes, with 10 to 20 bacteria per leukocyte. He is now studying these cells to determine if gonococci actually contain a substance which attracts leukocytes.

Disseminated Gonorrhea. The effects of untreated gonorrhea can be serious, leading to sterility or painful arthritis, or even life-threatening, as in the infrequent cases of meningitis, endocarditis, and gonococcemia.

Dr. David J. Drutz, an NIAID grantee at the University of Texas Health Science Center at San Antonio, has developed an animal model for disseminated gonococcal infections which should help scientists better understand the disease in humans. Dr. Drutz found that adult New Zealand white rabbits, when injected with penicillin-susceptible strains of gonococci, will develop not only gonococcal endocarditis, but also gonococcemia. In fact, the rabbits also developed gonococcal hepatitis, which can accompany the other two illnesses in humans. Previous investigators have also shown that there is a relationship between gonococcal susceptibility to penicillin and the capacity for the spread of bloodborne infection.

NIAID program-project director Dr. King K. Holmes of the University of Washington, Seattle, has been studying the gonococci involved in disseminated infections. Last year he found that these gonococci are of a single auxotype, that is, they require the same basic chemicals for optimal growth. Now, building on his earlier work, he, too, has found that this auxotype seems to be associated not only with susceptibility of the bacteria to penicillin, but also to resistance of the gonococci to killing by human serum. Furthermore, he has found evidence that the prevalence of this auxotype differs in various regions of the country; this may account for regional differences in the incidence of disseminated gonococcal infections. For example, in Seattle 50 per cent of the gonococcal samples studied were of this auxotype, in contrast to only six per cent of those from Norfolk, Virginia.

## Syphilis

Syphilis is caused by a spirochete, Treponema pallidum, a spiral-shaped, very motile bacterium. 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 usually 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 primary 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 for about two years from the time of initial infection. In the third or latent stage, the organisms, after a long period of dormancy, begin to attack the heart, brain, and spinal cord. Untreated syphilis can lead to mental illness, blindness, heart disease, and even death in the fourth stage, known as late syphilis.

Biology of Spirochetes. A principal hindrance to research on T. pallidum has been the inability of scientists to grow this bacterium outside 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.

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, Amherst, showed that this bacterium does indeed consume oxygen. Further studies by Dr. Cox this year under atmospheric conditions have identified glucose as an oxidizable source of energy for T. pallidum. He is now attempting to determine just how glucose is broken down by the organism.

Dr. Joel B. Baseman, an NIAID grantee at the University of North Carolina at Chapel Hill, is also interested in the role of oxygen in T. pallidum metabolism. He has demonstrated that T. pallidum metabolism is dependent on oxygen for stimulation of activities such as protein synthesis and motility (spontaneous movement). Motility of virulent T. pallidum was vigorous in the presence of oxygen and sluggish or inhibited in its absence. Dr. Baseman believes that, because of such findings, further attempts to grow this bacterium under anaerobic conditions or to use prolonged motility as the critical measure of optimal test tube growth conditions should be reevaluated.

In 1974, NIAID began a small contract program to stimulate research on growing T. palldium. 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, have been applying new methods of laboratory cultivation to this problem. Using improved growth media and various tissue cultures, these scientists have been able to increase the length of time that T. pallidum organisms remain viable and virulent in tissue culture. However, they have not yet observed reproduction of the organisms. Dr. Miller has also improved methods for purifying T. pallidum grown in rabbit testes, providing better material for use in other studies on syphilis.

NIAID grantee Dr. Delbert L. Harris is also pursuing the problem of growing this treponeme in his laboratory at Iowa State University in Ames. Dr. Harris is working with a new treponeme he discovered, T. hyodysenteriae, which causes a severe disease of pigs called swine dysentery. The first disease-causing treponeme to be grown in artificial medium, this bacterium consumes oxygen like T. pallidum. Although, so far, Dr. Harris has been unable to grow virulent T. pallidum in the same medium used for T. hyodysenteriae, his findings suggest that further study of this other treponeme as a model system may yet lead to laboratory cultivation of the syphilis bacterium.

Immunity and Vaccine Development. An understanding of the mechanisms of immunity -- the way in which the host protects itself against invading microorganisms -- is a necessary base for the development of preventive measures such as 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 a more important role.

Dr. Daniel M. Musher, an NIAID grantee at Baylor College of Medicine, has shown that certain white blood cells or lymphocytes, which are involved in cellular immunity, when obtained from syphilis patients, have suppressed responses to treponemes when combined with them in the laboratory. Such cellular immunosuppression might explain the progression of syphilis infection despite the presence of antibody.

Because lymphocyte reactions are associated with cellular immunity, Dr. Musher carried his investigations further and uncovered other paradoxes about the role of immunity in syphilis. In examining cellular immunity in rabbits, he found that it is actually enhanced when these animals are infected with T. pallidum. Since such enhancement usually means elimination of infecting organisms, he then studied the effect of further stimulating cellular immunity by using BCG, a vaccine for tuberculosis, but with no effect on T. pallidum. He is now working to determine whether immunity to syphilis can be transferred, using cells from infected or immune animals.

While investigators such as Dr. Musher are trying to unravel the intricacies of immunity in syphilis infection, others are approaching the development of a vaccine directly. Dr. Harris of Iowa State University is using his work with T. hyodysenteriae as a basis for such studies. He immunized rabbits with material prepared from this swine treponeme. Although the vaccinated rabbits showed a delay in the development of skin lesions after challenge with T. pallidum, they had no protection against systemic infection by the syphilis bacterium.

## 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 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 periodically.

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 its exposure to the virus.

Dr. Bernard Roizman, an NIAID grantee at the University of Chicago, has confirmed a long-time suspicion of his, that there are many varieties of the herpes simplex virus. In fact, he has found that there are at least 19 different strains of herpes simplex type 1 and perhaps as many of type 2. Recognition of this fact will facilitate epidemiologic studies. Furthermore, analyses of samples taken from a number of people have shown that the distribution of these variants in the body is not random. That is, certain variants were shown to have a predilection for the central nervous system and cornea.

Animal models represent an important step in research on any disease. Dr. Raphael Dolin of the Laboratory of Clinical Investigation, NIAID, has developed the guinea pig as an animal model for his studies of the immune response to herpes virus infections. Presently, he is also carefully measuring the cellular immune response of people with genital herpes infections, and his preliminary evidence indicates that individuals with recurrent lesions have somewhat elevated cellular immune responses during active outbreaks of lesions, as compared to those without recurrences.

Another animal model has been developed by NIAID contractors at the University of Utah College of Medicine in Salt Lake City. Following up on observations made by other scientists, Dr. James C. Overall showed that certain adult female mice may be used to study herpes simplex virus type 2 infection. These animals, after having the virus placed in their vaginas, developed disease there. The infection later spread to the spinal cord and then ascended to the brain, a condition that occurs only rarely in humans. This animal model of the human disease should permit the evaluation of potential drugs for treating both the local

genital infection and the more serious systemic form of herpes infection. The model should also facilitate study of how this virus causes illness and tissue damage.

Therapy and Prevention of Herpes Simplex Virus Infections. 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, chemicals known as antiviral substances which might prove useful in treating or preventing viral infections. Two such antiviral substances, adenine arabinoside (Ara-A) and disodium phosphonoacetate, have shown excellent activity against various herpes infections in animals. Further animal studies are now underway using disodium phosphonoacetate and Ara-AMP, a derivative of Ara-A, against genital herpes. Much work is needed, however, before these or similar medications could be licensed for general use.

A presently used therapy for herpes infections -- photodynamic inactivation or the so-called "dye-light" treatment -- is being studied by two groups of NIAID grantees. This method involves treating the herpes lesions with a dye and then exposing them to light. While with Harvard Medical School, Dr. Martin G. Myers, now at the State University of Iowa, evaluated this method in a controlled manner in 96 patients. The Harvard study failed to demonstrate the efficacy of neutral red dye and light in treating recurrent herpes infections. Other scientists have cited a potential risk of producing cancer with this therapy. Dr. Myers has therefore recommended that routine use of this therapy be discontinued.

Meanwhile, Dr. Michael Jarrett, working under the program-project grant at Baylor College of Medicine, has begun a controlled efficacy study of the use of proflavine dye and light in men and women with oral or genital herpes. In addition, he is conducting long-term animal studies to determine any cancer-causing potential of this treatment.

Also under the Baylor program-project grant are preliminary studies for developing a herpes vaccine. This work is under the direction of Dr. Joseph L. Melnick who has isolated a major protein from herpes type 2 virus and prepared antibodies to it in rabbits. In the laboratory, these antibodies inactivated herpes type 2, but not type 1 virus. Experiments are now in progress in rabbits to determine if this virus subunit could induce protection against an active herpes type 2 infection. As this protein subunit contains no genetic material, the subunit would presumably be free of cancer-causing material and would, thus, be safe to use. Population studies of herpes type 2 infections, cancer of the cervix, and related factors have suggested a possible link between the intact herpes 2 virus and cervical cancer.

Chlamydial Infections

Long recognized as a cause of one venereal disease, chlamydiae are bacteria which have only recently been implicated in other sexually-transmitted diseases. The most important human diseases these organisms cause are trachoma (an eye infection which may become chronic and lead to blindness) and two venereal diseases -- lymphogranuloma venereum or LGV (rare in this country, but more common in the tropics and semi-tropics) and nongonococcal urethritis (NGU).

In man, the symptoms of NGU mimic those of early gonorrhea, but in women the disease is less well defined at present and many women have no symptoms at all. Some experts believe that chlamydial infections of the eye and genital tract often go unnoticed because physicians in this country are not used to encountering them.

In order to better define the importance of chlamydiae in venereal diseases, two NIAID grantees are studying patients with genital infections. Dr. Julius Schachter at the University of California, San Francisco, has now tested approximately 3600 women and 1600 men for infection with chlamydiae, herpes viruses, and gonococci. Overall, in specimens from patients with symptoms, chlamydiae were recovered about twice as often as gonococci, and even more frequently than herpes viruses.

Dr. King K. Holmes at the University of Washington studied 245 men with non-gonococcal urethritis, overt urethritis, or gonorrhea and found that 42 per cent of the NGU cases were caused by Chlamydia trachomatis. This organism was also isolated from much smaller numbers of the other two groups. Herpes virus, cytomegalovirus, other bacteria, and Trichomonas vaginalis, a parasite, were not factors in infections in these men.

Control of NGU has been limited by lack of data about its cause. It is important to differentiate NGU from gonococcal infection since it does not respond to penicillin as does gonococcal infection. These two studies, therefore, should enable physicians to more accurately diagnose genital infections, thereby ensuring more effective therapy.

Dr. Almen L. Barron, an NIAID grantee formerly with the State University of New York, Buffalo, and presently with the University of Arkansas Medical Center, Little Rock, is interested in the potential of the guinea pig as an animal model for chlamydial infections. He has successfully infected male guinea pigs through their urethra or testes with the human LGV agent and is now planning to extend his studies to female guinea pigs. Similarly, he has infected male and female guinea pigs rectally with another chlamydial agent, guinea pig inclusion conjunctivitis (Gp-ic) agent, to simulate human rectal chlamydial infection.

Other Sexually-Transmitted Diseases

Still other infectious organisms are being recognized as present in the genital tract and possibly causing disease. NIAID grantees, especially scientists working under the program-project grants, are studying these in order to define their importance.

Trichomonas vaginalis, a protozoan, is a common cause of genital 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.

Since trichomoniasis is not life-threatening and effective drug treatment (metronidazole) is available, little research has been conducted on this disease. However, Dr. Miklos Muller, NIAID grantee at the Rockefeller University, is now investigating the basic biochemistry of T. vaginalis. From his studies, an understanding of the unique adaptation of this parasite to a predominantly anaerobic way of life is emerging. For example, the specific minute organ concerned with energy metabolism in this parasite is known as a hydrogenosome. Dr. Muller's research this year revealed that a novel enzyme, acetate thiokinase, seems to be the key in the energy-conserving role of the hydrogenosome.

Furthermore, the hydrogenosomes were shown to take part in an early step in the conversion of metronidazole to a biologically active compound. This has significantly increased understanding of the mechanism of action of this drug.

Mycoplasmas, especially one form known as T-mycoplasmas or Ureaplasmas, are other bacteria which have been implicated in sexually-transmitted diseases. They are suspected, but as yet unproven causes of human reproductive failure, spontaneous abortion, and nongonococcal urethritis. NIAID grantee Dr. Leonard Hayflick of Stanford University School of Medicine is studying the basic biology of Ureaplasmas in order to provide a better basis for immunological studies of this organism, as well as for efforts to determine its part in human genital disease.

The arrival of antibiotics seemed to promise control of sexually-transmitted diseases -- most notably, syphilis and gonorrhea -- which had plagued mankind for hundreds, if not thousands, of years; but recent increases in these two diseases are proof that the availability of effective antimicrobial therapy is not enough. In addition, recognition that other diseases may also be sexually transmitted has further complicated this public health problem. Research such as that supported by the National Institute of Allergy and Infectious Diseases is providing new hope for controlling all these diseases.

LEAD-BASED PAINT POISONING

Obligations

| | 1973 | 1974 | 1975 | 1976 Estimate | 1977 Estimate |
|---|---|---|---|---|---|
| Public Health Service: Center for Disease Control | $7,805,000 | $14,250,000 | $9,885,000 | $4,413,000 | $4,413,000 |
| Health Services Administration | 1/ | 1/ | 1/ | 1/ | 1/ |
| Office of Human Development | 1/ | 1/ | 1/ | 1/ | 1/ |
| Total | 7,805,000 | 14,250,000 | 9,885,000 | 4,413,000 | 4,413,000 |

1/ Obligations not identifiable.

CENTER FOR DISEASE CONTROL

Since 1972, grants have been provided to States and communities to identify children with increased levels of lead absorption and to provide medical and environmental services to protect those children from their lead sources and from reaching a stage of overt lead poisoning.

Lead seriously affects many bodily functions and can produce irreversible effects on the central nervous system. In addition, recent studies indicate that levels of lead absorption previously thought tolerable can result in metabolic disorder, mild neurological disability, and hyperactivity.

Childhood Lead Poisoning Prevention Programs provide the intensive outreach and followup necessary to identify and protect these children before irreversible neurological damage or acute suffering can occur.

In 1975, the Center for Disease Control recommended that lead screening projects incorporate a test which measures metabolic disturbance instead of blood lead levels. Pediatric management of children with evidence of lead absorption above 30ug/100ml whole blood who show evidence of metabolic disturbance was recommended. As a result of increased resources and more intensive screening practices, over 28,000 children with increased lead absorption were identified in 1975, 76% more than in 1974. Of these, 3,585 children had already reached a stage requiring treatment for lead poisoning. Totally, 440,650 children were tested in 1975 in 77 project communities with grant funds awarded late in 1974. Grants for the same number of community programs were continued in 1975.

In addition to administrative, technical, and consultative services, the Center for Disease Control maintains a laboratory proficiency program and assists local communities without lead programs to assess their needs. The number of communities receiving project grant assistance in 1976 and 1977 will decline as State, local and other Federal resources are used to maintain child screening and followup programs.

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Lead Poisoning

The Children and Youth projects are continuing to screen their populations for lead poisoning. In terms of their findings these programs still consider lead poisoning as one of the major public health problems among their patients.

There are increasing reports of "subclinical" effects of lead in children without overt evidence of lead poisoning. Psychological and other functional impairments have been reported in young children with evidence of undue lead absorption who are otherwise "asymptomatic." It has been suggested that the upper limit of normal blood level, set at 40 ug/100 ml may be too high, and that the interaction of lead with other metals and pollutants is further complicating the problem.

While the issue of low lead toxicity in children is far from clear-cut, the implications of many of the positive findings are grave, not only in terms of the new dimensions of the problem, but also in terms of the lack of any systematic effort at preventing continued further undue exposure of our population.

Maternal and Child Health
Obligations
(In Thousands of Dollars)

| | 1973 | 1974 | 1975 | 1976 Appro. | 1977 Est. |
|---|---|---|---|---|---|
| National Institutes of Health: | | | | | |
| National Institute of Child Health and Human Development[1] | 66,016 | 80,215[2] | 82,787 | 88,332 | 83,320 |
| Center for Disease Control.... | [3] | [3] | [3] | [3] | [3] |
| Health Resources Administration Bureau of Health Manpower... | --- | --- | 1,204 | 3,000[4] | [4] 7,000 |
| Alcohol, Drug Abuse and Mental Health Administration: | | | | | |
| National Institute of Mental Health..... | 56,434 | 67,754 | 78,601 | 76,238 | 49,676 |
| Health Services Administration: Bureau of Community Health... | [5] | [5] | [5] | [5] | [5] |
| Total..... | 122,450 | 147,969 | 162,592 | 167,570 | 139,996 |

1/ Included in the total amounts are funds for the Population Program that relate to MCHR as follows: 1973 -$12,871,000; 1974-$11,870,000; 1975-$11,338,000; 1976-$11,804,000; 1977-$11,510,000.
2/ Includes restoration of 1973 impounded funds in the amount of $8,386,000.
3/ Funds are reported under the categories of lead-based paint poisoning and immunization.
4/ These funds represent total appropriated request for this program. Estimates exclusively for Maternal and Child Health are not available.
5/ Obligations not identifiable.

MATERNAL AND CHILD HEALTH RESEARCH

The National Institute of Child Health and Human Development is the Federal Government's major research arm concerned with the health and well-being of mothers and children. The goals of the Institute are to enable men and women to safely and conveniently control their fertility and to be free of reproductive impairments; to assure a pregnancy and subsequent infancy of maximum health; and to define conditions for optimum development of the child so that full physical and mental potential can be attained in adult life. Programs of the Institute are carried out extramurally through the Center for Research for Mothers and Children and the Center for Population Research. Extramural activities include research grants, research manpower development awards, and research and development contracts. An Intramural Research Program includes biomedical research, behavioral research and clinical research carried out in Bethesda, Maryland.

Several Special Reports have been prepared in January, 1976 for the House Committee on Appropriations. These reports develop, in some detail, research efforts which impact on maternal and child health. The reports include: Report on Population and Family Planning Activities; Sudden Infant Death Syndrome; Mental Retardation Programs; and Hearing, Speech, and Language.

NATIONAL INSTITUTES OF HEALTH

National Institute of Child Health and Human Development

This report will highlight the maternal and child health problems which the Institute seeks to address and will present an overview of several new research directions and recent significant findings.

Health problems of mothers and children are best described by the following statistics:

- Although the national infant mortality rate has fallen from 22.4 to 17.6 deaths per 1000 live births over the last six years, the United States has dropped from fourteenth to fifteenth position among developed countries.

- Approximately 7.6 percent, or 238,000, of the infants born in the United States in 1973 were born either too soon or too small, weighing less than 5 1/2 pounds. One out of every four of these babies had a teenage mother. Approximately 42,000 of these babies died within their first month of life.

- Of the low birth weight babies born each year, about 60,000 will have life-long disabilities, including mental retardation.

- Approximately 7,500 infants succumb to the sudden infant death syndrome each year.

- Of all babies born in this country, 3.5 percent show evidence of a birth defect during the first month of life; 7 percent have developed identifiable defects by the end of the first year.

- Approximately 7 million children between the ages of 10 and 18 in the United States suffer some major impairment including communicative disorders, learning disabilities and aberrant functional and skeletal development.

- Over 20 million Americans, representing the families of our Nation's more than 6 million mentally retarded persons, are directly affected by the problem of mental retardation.

NEW DIRECTIONS; RECENT FINDINGS

Studies in human fertility are centered around the development of safer, more acceptable, and more effective means of fertility regulation. In addition to studies of chemical regulation, we are exploring the reliability and utility of other, "natural," family planning methods. A contract has recently been signed with Cedars-Sinai Medical Center in Los Angeles to evaluate the efficacy of a "natural" method based on recognition of changes in the character and quantity of cervical mucus during the normal menstrual cycle. These changes will enable a woman to determine when she is in the fertile phase of her cycle. The method will also help infertile couples to maximize their chances of achieving conception.

A major advance in preventive medicine occurred in October, 1975, when NICHD released the results of its National Registry for Amniocentesis. Although tapping of amniotic fluid had been used as a prenatal diagnostic technique for a number of years, a number of obstetricians were concerned about possible unknown risks associated with the procedure. The study determined that amniocentesis performed in the middle three months of pregnancy is a safe technique, applicable to large segments of the population. Over two hundred disorders based on chromosomal aberrations of inborn errors of metabolism can be diagnosed in utero using amniocentesis. The physician is now in a position to assure many parents-at-risk that they are capable of producing healthy children, thereby alleviating a major source of parental anxiety.

In addition to the disorders detectable by amniocentesis, there exist a myriad of structural malformations which have their origin in fetal development and may persist to handicap the victim for the duration of his or her adult life. The well-known "thalidomide babies," along with thousands of victims of the 1964 rubella epidemic, provide classic examples of such defects. But in most instances of congenital malformations, the causative factors, whether genetic or environmental, remain completely unknown. We plan to develop animal models which will permit us to experiment directly on the fetus during the time when the various organ systems are being formed.

While elimination of birth defects would considerably improve the chances for every child to have a healthy start in life, there are other health hazards which may endanger even the well-endowed, well-formed fetus. These include intrauterine growth retardation, premature birth, and even the birth process itself. We are currently funding a number of studies to determine the exact effect of maternal malnutrition on the birthweight and subsequent development of the child. Some studies have shown that children whose mothers received adequate protein and calories during pregnancy weighed more at birth and developed more rapidly than children whose mothers were malnourished. The Institute has also undertaken a significant effort to determine the mechanisms responsible for the premature onset of labor and to identify the causes of intrauterine growth retardation.

If we could ensure that all newborns were free of defects and mature enough to cope with the hazards of the first month of life, we would automatically eliminate much of the infant mortality and morbidity in this country. However, there are certain additional dangers which may jeopardize the life of even the well-born infant. The Institute is particularly interested in two of these problems--maternal deprivation and the sudden infant death syndrome.

Maternal deprivation is a term used by behavioral scientists to refer to deficiencies in the immediate human environment which surrounds the infant. All infants need to be cuddled, played with, and otherwise stimulated in order to develop normally. When this stimulation is lacking, the result may be impaired development or, in the most extreme cases, early death. The Institute has been conducting a number of studies in this area. One group of researchers has shown that interaction between parents and their newborn infants actually improves the health status of the infants, in addition to enhancing the emotional security of the parents. These results are of particular relevance to the care of premature infants, who are often kept in virtual isolation for the first few weeks or months of their lives. We now realize that we have to make sure that these infants receive adequate stimulation in addition to good medical care.

We are also committed to saving the thousands of infants who survive the hazards of the first few months of life, only to fall prey to the sudden infant death syndrome. The sudden infant death syndrome, or SIDS, is the leading killer of infants in the postneonatal period, claiming more than 7,500 victims annually.

The Institute has assumed the primary Federal responsibility for the investigation of SIDS, and now has over a hundred research efforts in progress around the nation. These studies have radically altered the traditional picture of SIDS as a mysterious ailment which strikes a healthy infant without warning. We are now convinced that there is no single mechanism involved in SIDS. Nor were all of the SIDS victims as healthy as they appeared to be in the months preceding their death. Many of them suffered from subtle defects of a neurological, cardio-respiratory, and metabolic nature. We are approaching the time when we will be able to use these signs to identify the infants most at risk for SIDS, and, by appropriate treatment and devices, prevent many of these deaths. In addition, these advances should help the parents of past SIDS victims to overcome their guilt feelings and their anxiety about the fate of future children.

For every family which loses a child in infancy, there are others who must face the ongoing tragedy of mental retardation, one of the most complex and critical problems of human development. The Institute has an enormous investment in this area. Investigations into the prevention and treatment of mental retardation are carried out in more than two hundred projects directly supported by the Institute and in 12 mental retardation research centers around the United States. In the past year scientists have identified certain basic steps in the maturation of the nervous system which must precede normal intellectual and behavioral development. Other investigators have achieved promising results in habilitation of the mentally retarded using behavioral adaptation techniques.

MAJOR RESEARCH PROGRAMS

The Institute is compelled to examine all of the things which can go wrong between the decision to conceive and the emergence of the child as a self-sustaining individual. It has attempted to focus its research efforts in areas which offer promise of eliminating the major hazards of early life. Knowledge exists about which risk factors pose the greatest threat to the infant: to be born too soon, or too small; to be born into poverty, or to a diseased or malnourished mother; to be born to a mother who is still in her teens or over 40; and to be born unwanted. In order to minimize these risk factors, new knowledge must be sought and more efficient ways of applying it must be found. This can probably best be accomplished by means of interdisciplinary research efforts involving both scientists and clinicians.

Toward this end, the Institute will establish, through its Center for Research for Mothers and Children, a national network of research centers devoted to the study of diseases and disorders of pregnancy, infancy, and early childhood. These Major Research Programs (MRP) for Mothers and Infants will be distributed around the nation. Each will be devoted to a particular problem of maternal and child health, and each will allow researchers and clinicians to be brought together in a situation which will foster maximum exchange of information.

## Center for Disease Control

### Immunization

Since 1963, the Center for Disease Control has provided project grant and technical assistance to State and local health agencies for childhood immunization programs. With this assistance these health agencies have conducted intensive immunization programs against poliomyelitis, measles, and rubella, and have carried out routine immunization programs against diphtheria, pertussis, and tetanus.

These efforts have had a dramatic impact on children's health. Reported measles cases have declined from 261,904 in calendar year 1965 to 22,094 in 1974, and reported rubella cases fell from 57,686 in 1969, to 11,917 in 1974. However, both measles and rubella were up in 1975 compared to 1974 (10% and 37%, respectively).

While overall disease morbidity for childhood vaccine preventable diseases has been declining, concentrated immunization efforts will be continued. It is estimated that because of inadequate protection more than 18 million children are susceptible to poliomyelitis, 22 million to diphtheria, pertussis and tetanus, 11 million to measles, 31 million to mumps, and 16 million to rubella. Recent data suggests that measles may once again be increasing.

### Lead-Based Paint Poisoning Prevention

It has been estimated that 600,000 children each year suffer from undue lead absorption. Of these, 6,000 may suffer permanent neurologic damage and 200 deaths may result.

The children most at risk of lead poisoning are generally from lower socioeconomic urban areas where housing contains many old layers of paint with high concentrations of lead. During 1975, 77 local communities have been funded to provide detection, treatment and hazard control services, and through these programs over 440,650 children were tested, an 18.5% increase over 1974. Door-to-door screening activities have encouraged greater participation by children who normally would not be in a child care system. The number of children receiving chelation treatment has remained relatively constant over the past three years, while the number of children found with undue lead absorption has increased by 76% in 1975 alone. This would indicate that more children are being identified prior to the need for chelation. Early identification of children with undue lead absorptions, followed by appropriate pediatric management and environmental intervention, will result in a significant reduction in the later sequelae of lead poisoning, including mental retardation, neurologic impairment, hyperactivity and death.

Local Childhood Lead Poisoning Prevention activities are coordinated with and often are an integral part of the Maternal and Child Health Services provided by the health department, Neighborhood Health Centers and EPSDT programs in a community.

HEALTH RESOURCES ADMINISTRATION

Health Manpower

Maternal and Child Health

One of the primary goals of the health manpower programs is in expanding the role of the health professional. In the area of Maternal and Child Health, educational programs for experienced registered nurses to be trained as nurse practitioners or nurse-midwives have been the major focus of the health manpower programs. Grants have been awarded to institutions to provide specialized educational training of nurses in Pediatrics, Obstetrics, Gynecology and Geriatrics. These nurses are able to deliver specialized care to women and children in hospital nurseries, newborn intensive care centers, community health settings, and rural areas where there is a shortage of physicians. The recent enactment of the Nurse Training Act of 1975 provides authority for training Nurse Practitioners through FY 1978.

Additionally, a study is currently being performed to determine the impact and feasibility of hiring Child Health Associates, health care extenders, for use in private practice settings.

NATIONAL INSTITUTE OF MENTAL HEALTH

Maternal and Child Health

The number of children and youth (birth through 18 years) needing professional intervention and care is estimated at seven million. NIMH studies indicate that over 90% of these young people will not receive needed services.

In 1973, there were 25,830 admissions to State and county mental hospitals. Almost one-third of these young people were 10-14 years old. There is also a disturbing trend concerning non-white children and youth. Last year 40% of this country's non-white children live in poverty level families. In addition, surveys reveal that these children are four times more likely to end up in correctional institutions than white children. There is now clear evidence of a trend towards placing more and more such individuals in correctional settings.

The existing trend of increasing divorces, remarriages, number of children involved in divorces, and increasing single-parent families, especially female-headed, is expected to continue. Already there is some evidence of increased contact with the mental health system by individuals caught up in this social phenomenon. We have no realistic idea, however, of the demands such social change may place on the mental health service system or what significant impact, if any, it will have on the various forms of psychosocial dysfunction.

The physical environment, food and nutrition may become an increasing concern of the mental health community. Evidence continues to accumulate concerning the impact of nutrition on brain development. Evidence is also accumulating concerning the effects of heavy metals such as lead on cerebral function. Finally, serious questions are now being raised concerning the effects of foods as well as their additives (flavors, coloring agents, preservatives) on human behavior (activity level and moods).

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## Organizational Developments

A major effort to strengthen child mental health activities within the NIMH was the reorganization of three intramural research laboratories and branches into the new Laboratory of Developmental Psychology. Other actions that will assist this effort further are the creation in December, 1974 of the NIMH Child and Youth Advisory Group (CYAG) to make policy recommendations to the Institute's Director regarding child mental health research and activities; and the creation a few months ago of the NIMH Services Manpower Task Force to explore child mental health issues in terms of service, manpower and research needs.

## Research

Major child mental health research areas within the Institute's grant program included studies in the traditional psychological aspects of behavior (i.e., cognitive, perceptual, and emotional processes, motivation, learning language and personality); studies on the dysfunctional child (childhood psychoses and autism, neuroses and severe behavioral disorders, etc); studies in social and cultural correlates of behavior (i.e., family structure and dynamics, socialization, attitudes, values, etc.); and studies in prevention and treatment (i.e., chemotherapy, community action and school programs, etc.). Of lesser emphasis, but still interwoven within our program activities and interest in the total child, were studies dealing with biological and physiological correlates of behavior (i.e., maturation, growth, development) and studies geared to improving techniques and methodological aspects of research including early screening procedures, and diagnostic and prognostic indicators.

Two notable contracts awarded last year in the child mental health area include one to the University of Minnesota for a survey, synthesis and critical evaluation of the experimental literature relating to emotional development in infancy and early childhood, to be followed by recommendations for further avenues of research in this area. The second contract, to evaluate the impact of the NIMH supported research (during FY 71-FY 75) in the field of cognitive and social enrichment of children at risk in terms of their subsequent psychological and social development and problems, was awarded to the University of Kansas. The study is expected to also provide recommendations for the further level of NIMH research in this area.

Some new significant findings in child mental health have been reported by NIMH grantees. There are new data challenging assumptions of several developmental theories concerning the egocentricity of young children's thought processes. Based on a longitudinal study another grantee has been able to replicate validity and reliability for a battery of tests highly predictive of risks for subsequent reading disabilities in white boys. In pediatric psychopharmacology, an investigator found that a significant number of hyperactive children treated with methylphenidate (Ritalin) heretofore discontinued if they failed to show adequate response after 4 weeks, did show satisfactory improvement after 8 or 12 weeks of treatment. Another grantee found a significant association between stimulant drug treatment and cardiovascular effects. Thus, methylphenidate used in the treatment of hyperactive children has been found to increase heart rate, and apparently tolerance does not develop with long-term treatment.

In another area, the Institute has been involved for the past few years in supporting efforts to develop a method for monitoring televised violence. One grantee has recently submitted a report with recommendations on the research and developmental efforts required for the development of a useful multidimensional

profile. Another investigator who has been developing and testing such a profile, reported no significant reduction in televised violence over the past 5 years. This year, the Institute plans to combine the efforts of both investigators and to have the final report published on this issue, demonstrating the feasibility of the multidimensional monitoring profile.

Over the past year, the NIMH Center for Studies of Child and Family Mental Health has been involved in a variety of activities on behalf of children spanning special mental health programs such as runaways and their families, alternative group foster homes, and the administration of the NIMH child advocacy, child abuse and neglect and State development programs. In addition, Center staff in collaboration with other NIMH components developed a working conference to explore the question of early childhood depressions from infancy through puberty. In yet another sphere, the Center has been, in collaboration with NICHD, spearheading the area of primary prevention for the Institute, and has recently conducted two workshops on major public health/mental health problems under this rubric: the impact of infant death on parents and siblings, and the behavioral and mental health considerations of SIDS. Center staff have also been involved in coordinating and developing child mental health components of National conferences in areas such as early child care intervention and parent education research.

The NIMH Center for Studies of Crime and Delinquency focused on funding basic research studies into the causes of deviant and delinquent behaviors, and studies on community-based treatment models for delinquents. The Center also funded training projects dealing with professional services to delinquent youths, in particular social work and corrections services. The NIMH Center for Studies of Metropolitan Problems is concerned with child and youth activities through its studies of new social forms, which include new family forms. The Center has recently funded a unique experimental training project to Eastern Michigan University which trains foster parents to care for dependent children. With the increasing movement to deinstitutionalize dependent children, there is an increasing need to help caretakers understand the needs and wants of children. Finally, the Center for Studies of Minority Group Mental Health Programs has funded several research projects in the area of school mental health, concerned with such factors as school performance and self conceptions of minority students, student drop-out rates, student aspirations, enrichment programs, and culture-specific testing instruments.

The Institute's Intramural Research Program has continued its program activities in basic research of the developmental processes and behaviors of infants and young children, as well as its clinical and behavioral studies of the biological and genetic aspects of child mental illness.

Infancy is an area of heavy research involvement, dealing with infant perception, cognition, learning and infancy as a baseline for later human development. For example, one longitudinal study found the 2 to 3 year level may be the critical point for intervention in deviant patterns of social behaviors. The same investigators reported that in children with high levels of disruptive and impulsive behaviors, the presence of multiple minor physical anomalies is related to problem behaviors. In boys, the anomalies are consistently and strongly related to high level disruptive activity, whereas in girls the associated behavioral disturbances have a less consistent form. The association of multiple physical anomalies and problem behaviors is interpreted by the researchers as an interaction of congenital and experimental factors. They replicated their findings with two large samples of school children ages 6-12.

A major commitment of time and resources has been given over the past year to a second set of infant studies: developing procedures and sophisticated instrumentation and technology (for measuring habituation and discriminative conditioning) adapted to the very young. The studies themselves have dealt with habituation and discriminative responses in the infant, considered to be the precursors of problem solving behavior. Differences in such prescribed perceptual and intellectual capabilities, may have potential as standard diagnostic or infant screening devices.

Studies relating to affective social development emerging sensitivities to affective events (anger, pain, fear, joy, etc. in persons around them) in the environment of one and two year olds, and their developing sensitivities to the affective consequences of their own behavior for others. Allowing for individual variation, young children as early as one year of age were found to be finely attuned to and discriminating in response to other's affects. Analyses now in process are attempting to understand the association between experiential factors and differences in children's sensitivities to affect.

Other intramural researchers are engaged in a current effort in childhood mental illness involving inpatient and outpatient programs. The outpatient program is focusing primarily on a familial genetic study in which the incidence of depression is being determined in the children of adult patients presently or formerly hospitalized for affective illness at the Clinical Center of NIH. The children and their families are being studied in terms of clinical characteristics, genetic patterns, and biological parameters that may serve as genetic markers. The inpatient program is focusing primarily on children, aged 4-12 years, with a combination of learning disorder and hyperkinetic, hyperaggressive behavior. Those areas of current focus involve urine and plasma studies to contribute to the understanding of neurotransmitter functioning in these children, studies correlating behavioral response with the pharmacokinetics of methylphenidate and d-amphetamine are in progress and the investigation of drugs not previously used for MBD (as piribedil) are planned. A technical advance that seems promising is the development of a constant motor activity electronic monitor (worn by the child as a "wristwatch").

## Training

The Institute's Manpower and Training program continued to fund a very substantial number of projects (more than seventy in psychiatry, for example) which support the training of specialists in the mental health of children and youth. Fiscal year 1975 funding allocable to the support of such training was approximately $15 million (1/3 of this was for child psychiatrist training).

Among the more innovative projects recently funded is one which will operate and evaluate a program to train mothers as paraprofessional mental health workers. These mothers when trained will conduct a 16-month series of weekly visits to the homes of mothers and infants in their community using a cognitive developmentally based curriculum. During the program these "home visitors" will work with the mothers and infants to support and extend the mothers' child-rearing skills and to help the mothers to see themselves as their infants' most important teacher, to share information between mothers and home visitors, and to provide opportunities and environments conducive

to the infants' cognitive growth. In addition to training the paraprofessional mothers initially, the project seeks to set up a continuing process by which each of those mothers trained recruits and trains additional mothers.

## Services

A wide range of projects relating to the delivery of mental health service for children is being supported by NIMH. These include projects focused on a variety of preventive activities and on identification of incipient problems, as well as programs for children and families where problems already exist. One prototype project is exploring methods for increasing systemization in research and development programming for children. Some of the other major child-related activities of the Institute concern the financing of children's services. These have included an analysis of voluntary health insurance coverage for children's services and study of financing of children's services in residential treatment centers under the CHAMPUS program. The NIMH Mental Health Study Center is currently proceeding with work on establishing a national infant mental health center. This is aimed at forming the nucleus for a communications and information network among outstanding clinical programs focused on vulnerable infants and their families. In addition, Study Center staff continue their work on a broad spectrum of studies relating to children; these range from projects concerned with infants and day-care programs to studies relating to adolescent mental health needs.

## Public Education

In other areas, NIMH staff develop publications, films, and communications oriented conferences designed to foster greater public awareness in the broad areas of child mental health and illness. As some indication of the scope of the dissemination effort, a recent analysis of approximately 85,000 requests for public information and 9,000 requests for such technical information services such as computer prepared bibliographies on specific topics, shows that 5.3 percent and 12.2 percent, respectively, of those inquiries pertained to child related topics.

A film designed to educate young mothers about the prevention of post-partum depression is being produced. When completed, the film will be made available to community health and mental health agencies, maternity programs, and community service agencies.

The NIMH sponsored a conference on death in the family, aimed at strengthening, through communication and education, the capabilities of the young child to cope with the death of family members. The conference was attended by mental health specialists and communications experts including representatives from popular children's TV shows. Educational materials developed as a result of the conference will be made available nationally to families and to mental health service programs.

## Statistical Developments

The Institute has also compiled basic population data from the U.S. Bureau of the Census and other sources on children and adolescents focusing on demographic, socioeconomic and family characteristics which may denote stressful situations which create potentially high risks for the development of emotional or mental disturbances, delinquency and other manifestations of maladjustment to social norms. In addition, data from United Nations sources and reporting systems of other countries are being examined as potential sources of information concerning the mental health status of children and youth in other countries. Also, under contract with the University of Rochester School of Medicine and Dentistry, the Institute is conducting a feasibility study of the role of pediatricians in the delivery of mental health services to children. The project will develop the forms, procedures and proposal for the conduct of a definitive community-wide study, and will be concerned with the extent to which pediatricians detect, treat and refer patients with mental health problems.

## Child Abuse and Neglect

Child abuse and neglect has been a priority issue within NIMH during the last three years stemming in part from an HEW department-wide initiative during FY 1974. This initiative resulted in contracts studying the legal aspects of child abuse and neglect, the role of mental health services in the treatment of child abuse and neglect cases, the training of mental health workers and other professionals to understand and work with this problem, and the collection of baseline data on the incidence of child abuse and neglect. The initiative also resulted in the funding of a five year longitudinal study on the effect and treatment of child abuse and neglect. The results of these efforts will be available, for the most part, at the end of this fiscal year.

The Child Abuse program at NIMH is presently focusing on youth as an example of a specialized problem which affects the mental health of young people. At present, four contracts have been awarded to obtain information pertinent to this area. Three are to agencies which work mainly with adolescents and are directed at collecting incidence data on abused young people. The fourth grant was awarded to the University of Minnesota to run a conference on the problems of adolescent abuse and to prepare a monograph. This Child Abuse program is an extension of present NIMH work with runaways and alternative youth services.

The Tri-Agency Child Advocacy program is now in its fifth year of operation. Of the 11 projects funded, three were terminated over the last year and eight are currently being funded. Plans are being developed to evaluate the impact of the program in terms of three major initial goals: the improvement of service delivery to children and families who did not previously have access to many human services; third party effects on the reorganization of service delivery systems at the community and State levels; sufficient success to attract alternate funding beyond the period of Federal support.

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Maternal and Child Health

Children receiving health services in FY 73 from Title V assisted State Crippled Children's Programs included 9,893 with spina bifida and/or myelomeningocele. Of these, 15.7% or 1,557 were new cases referred that year. These children frequently require a range of services including hospitalization, treatment by a variety of medical specialists, and services from many health professions including nursing, social work, and physical and occupational therapy. Some children with spinal cord injuries also received services from the State Crippled Children's Programs. In general these efforts are directed towards helping the child achieve optimum function and are not those purely of maintenance.

Title V funds also support training and demonstration projects which provide model care for children with these conditions. Two projects, "The Project for Children with Handicapping Conditions," Dr. Mary Ames, the Children's Hospital of Philadelphia, and "Spina Bifida Demonstration and Service Clinic," Dr. Chester Swinyard, New York University Medical Center, have nationwide recognition for the care of these children and training of professionals to care for them. Many other Title V supported multidisciplinary clinics for handicapped children include children with spinal disorders in their caseload.

Some of the Title V research projects on the care of children with multiple handicaps have included children with myelodysplasia. One study recently completed, "Cost and Utilization Patterns of Rehabilitation Service," Dr. David MacFarland, Crippled Children's Division, University of Oregon, included an analysis of the costs of care to the families of children with myelomeningocele. One project supported by the MCH special foreign currency program at the Institute of Mother and Child, Warsaw, entitled "Medical and Social Rehabilitation of Children with Myelomeningocele" demonstrated the need of a multidiscipline team for such cases.

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